Maternal and Child Health Services
Title V Block Grant

State Narrative for Florida

Application for 2015
Annual Report for 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are on file with the Department of Health's central office. The assurances and certifications can be made available by contacting:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input begins with the Healthy Start coalition local needs assessment process and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for needs assessment, plan development, and ongoing implementation, and consumers serve on the coalition boards. Coalitions encompass minority participation on the boards, and emphasize minority input in their assessment of local needs. Headquarters MCH staff review and evaluate coalition needs assessments, service delivery plans, and implementation reports and use this information in planning MCH programs.

We will make the application available over the Internet on our department website. The most recent application, or the current application when it is final, can be found at http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-block-grant.html

/2013/ Healthy Start Coalitions provide public input that assists in the determination of the services needed to identify priority target populations. Coalition board membership must include consumers of family planning, primary care, or prenatal care services, at least two of which are low-income or Medicaid eligible. Other members represent county and municipal governments, social service organizations, and local education. Along with the representation of local health departments, health advocacy interest groups, migrant and community health centers, hospitals, local medical societies, and others, this helps to ensure widespread, inclusive input. In addition, in the course of developing their service delivery plans, coalitions use surveys to gain additional input from both providers and the general community, and share that information with the Department of Health. //2013//

/2013/ Local Health Departments are required, as recipients of Title X funding, to establish an advisory committee of five to nine members who are broadly representative of the community to review and approve all informational and educational materials prior to distribution to ensure the materials are suitable for the population and community for which they are intended. The advisory committees also discuss and advise the local staff on community concerns and needs as they relate to the reproductive age population. //2013//

/2014/ Children's Medical Services (CMS) enrollees receive medical and support services through 21 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs. CMS has a strong partnership with University Health Systems. Children's Medical Services Medical Services Regional Medical Directors work for the Florida Department of Health; many have private practices, or work with universities and hospitals. Each quarter the Medical Directors meet and discuss program direction, emerging issues facing children with special health care needs, and health delivery systems. This group serves as an advisory group to CMS State Leadership in influencing policy and program direction.//2014//

/2014/ Children's Medical Services contracts with the University of Florida Institute for Child Health Policy to produce the Family Satisfaction Report. This report presents the findings of a statewide satisfaction survey of parents and guardians whose children are enrolled in the network. The patient experience and outcomes of CSHCN, and the satisfaction of their parents are important indicators of the health of these children and the quality of the services they receive. The report presents key findings and recommendations based on the following modules: demographics, satisfaction, CMSN care coordinator feedback, transition, quality of life and functioning, and CAHPS. The survey is conducted by telephone. The information provided in this annual report is used for policy direction, policy revision, program planning, and quality improvement initiatives. //2014//

/2014/ The CMS Sexual Abuse Treatment, Child Protection Teams, Cardiac, Partners in Care: Together for Kids, Transition and Newborn Screen Programs work with statewide consultants, program steering committees, or advisory groups. These groups have representatives from health advocacy groups, community health centers, hospitals, local medical societies, physicians, and families, to ensure widespread, inclusive input in program evaluation, program direction, and quality improvement activities. //2014//.

/2015/ In an effort to increase family participation, the department selected a family delegate to represent the state for the Association of Maternal and Child Health Programs (AMCHP). In addition to having voting rights on AMCHP issues, the family delegate will help us establish linkages with families in Florida and ensure they receive relevant AMCHP information. The family delegate participated in the 2014 AMCHP Meeting in order to add a family perspective to the delegation, as well as learn more about MCHB, Title V, and the MCH block grant. //2015//

/2015/ The American Indian Health Advisory Committee (AIHAC) was created in 2010 to provide guidance to the Office of Minority Health (OMH) on issues impacting American Indian populations residing in Florida. The committee consists of 15 representatives from Tribes and stakeholders serving American Indian communities and includes the OMH Liaison. The OMH hosts monthly conference calls with the committee so they can easily present their interests and input to the Department of Health. The Maternal and Child Health Section has reached out to the AIHAC through one of these calls to enlist a representative to participate in the 2015 Title V MCH Needs Assessment. This representative will be able to provide the American Indian's perspective for MCH health matters. //2015//

/2015/ In their efforts to complete next year's needs assessment, CMS will be seeking input from families and clients. CMS anticipates that at least one family representative,

identified by local CMS area offices, will participate in their Needs Assessment Advisory Committee. Their goal is to have family involvement in each of the needs assessment subcommittees as well, which would mean three additional family representatives. CMS also intends on surveying a representative sample of families with enrolled children under the age of 14, as well as survey a representative sample of enrolled clients between the ages of 14-21, in order to obtain input from both the child and the family on perceived health care needs. Surveys will be conducted through a survey tool such as Survey Monkey using email addresses on file with CMS Care Coordinators, as well as paper surveys that could be completed in the waiting room when they attend a CMS Clinic at local CMS Area Offices. //2015//

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The needs assessment process resulted in the identification of the following issues as priority needs for the Florida maternal and child health population, including children with special health care needs:

1. Prevent unintended and unwanted pregnancies.

2. Promote preconception health screening and education.

3. Promote safe and healthy infant sleep behaviors and environments.

4. Prevent teen pregnancy.

5. Improve dental care access, both preventative and treatment, for children.

6. Increase access to medical homes and primary care for all children, including children with special health care needs.

7. Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.

8. Increase early intervention services for children with special health care needs.

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. There was substantial input from key stakeholders and providers. A needs assessment advisory group was formed that consisted of key partners in maternal and child health as well as consumer representation. This advisory group made initial recommendations using a nominal group process. There was consensus among the group especially around the issues pregnancy prevention, preconception health screening and education, and promoting safe infant sleep behaviors. Increasing access to primary care and medical homes for children, particularly children with special health care needs was also identified as a priority need, as well as increased early intervention services and health care transition.

/2013/ The Infant, Maternal, and Reproductive Health Section developed a priorities and performance measure worksheet to track progress on the issues identified in the five-year needs assessment. For each priority, a chart was developed to identify and track activities and strategies, persons responsible, deadlines, evaluation, and progress made in addressing priority issues. //2013//

/2013/ During 2012, staff from the Infant, Maternal, and Reproductive Health Section and the MCH Practice and Analysis Unit have met to develop health problem analyses (HPA) for each of the priorities related to infant and maternal health. They have identified major risk factors as well as both direct and indirect factors that contribute to the identified problems. Logic models have been developed that identify programs and funding that address the problem (inputs); activities and the persons or entities providing each activity (outputs); and the short, medium, and long-term impacts that identified activities have on the problem (outcomes). The HPA and the Logic Model is the basis for determining appropriate strategies to address each of the priorities. //2013//

/2014/ The department continues efforts to address priority needs identified in the 2010 five-year needs assessment. The department conducts a quarterly conference call with lead persons assigned to the Collaborative Innovation and Improvement Network (CoIIN) strategic priority areas, who facilitate activities needed to implement each strategy. The quarterly conference calls provide updates and solicit input on the activities and strategies identified. This helps document progress, revise strategies, and brainstorm new ideas. Priority needs currently being addressed utilizing the CoIIN initiative include preconception counseling, back sleeping, and bed sharing. //2014//

/2015/ The department continues efforts to address priority needs identified in the 2010 five-year needs assessment. We are currently working on the 2015 five-year needs assessment. //2015//

III. State Overview

A. Overview

Florida is the fourth most populous state in the nation, and the diversity of its population creates unique challenges. The Florida Legislature, Office of Economic and Demographic Research (EDR) estimates there were 18,818,998 residents in Florida in 2009. This represents a 17 percent increase over the 2000 EDR estimate of 16,074,896 residents for 2000.

According to the 2009 EDR estimates, females account for 51 percent of the total population. There are 4,150,372 children under 18, which is 22 percent of the total population. Estimates indicate there are 3,302,610 residents 65 or older, 17.5 percent of the total. Of those, 524,289 or 2.8 percent of the total are 85 or older. Of the total population, 80.7 percent are white, 16.5 percent black, and 2.8 percent are nonwhite other. Florida residents also reflect diverse ethnicities, as evidenced by the 24 percent who are identified as Hispanic. Of all residents over 5 years of age, 23.1 percent speak a language other than English at home.

/2013/ According to EDR estimates, there were 18,905,048 Florida residents as of April 1, 2011. //2013//

/2015/ The Florida Legislature, Office of Economic and Demographic Research (EDR) estimates that by June 30, 2014, the population of Florida will reach 19,548,031. With expected growth rates of over 1.3 percent per year in the coming years, Florida will soon surpass New York as the third most populous state, following only California and Texas. //2015//

The diverse population creates unique challenges for the Title V program. The programs within Title V must tailor services to meet the needs of different cultures. We produce pamphlets and other educational materials in English, Spanish, and Haitian Creole. Efforts are made to ensure clinic staff represents the diversity of their local clients. The Title V program and both private and public health faces additional challenges in meeting the needs of tourists, illegal immigrants, and other temporary residents in Florida.

/2015/ According to calendar year 2013 population estimates provided by the Department of Health, Office of Health Statistics and Assessment and in consultation with the EDR, 78.3 percent of the population in Florida is white, 16.6 percent black, and 5.1 percent other. Of the total population, 23.4 percent are Hispanic, 66.6 percent non-Hispanic. Of the total population in Florida, 30.6 percent are between the ages of 0-24, approximately 52.4 percent are 25-64, and 16.9 percent are 65 and older. //2015//

Florida is a temporary home to over 80 million tourists and visitors each year. This constant influx places a significant burden on the health care system. Migrant farm workers and other undocumented aliens are also populations that create significant impact on public health services and resources. According to a report by the Pew Hispanic Center, Florida was home to 1,050,000 illegal immigrants in 2008, following only California and Texas. In 2008, Florida accounted for 9 percent of the total illegal immigrants in the nation.

/2013/ According to Pew Hispanic Center estimates, Florida was among four states that show a significant decrease in the number of unauthorized immigrants over the past two years. Florida had the largest decrease, going from 1,050,000 unauthorized immigrants in Florida during 2008 to 850,000 in 2010. This decrease may be attributed to the weakened economy and the lack of jobs, as there have not been major changes to state laws or policies regarding this population. Estimates are based on data from the Current Population Survey conducted jointly by the U.S. Bureau of Labor Statistics and the Census Bureau. //2013//

Historically, many illegal immigrants have come to Florida seeking jobs, particularly in agriculture.

Construction jobs and service-related jobs have recently seen tremendous increases in the use of illegal immigrants as a source of cheap labor. Following a trend in the 1990s that saw some advancement in the pay and benefit opportunities for immigrant labor, recent trends indicate pay is decreasing and services are becoming scarcer.

The large illegal immigrant population can have a taxing effect on the social service system, as illegal immigrants and their families need medical care and other services as well. Medicaid costs for just the births for this population are staggering. For example, Medicaid paid approximately $15.3m for 5,332 deliveries to undocumented aliens in state fiscal year FY98-99. A decade later, that amount increased to over $85.4m for 18,220 deliveries in FY08-09. This does not include births to illegal immigrants for which the hospital absorbed the cost. Children born here to immigrant families are U.S. citizens. Without the same advantages of others, many of these families face generations of poverty-level existence, creating the possibility of years of public support and costs.

/2012/ There were 17,695 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2009/2010, at a cost of $86.5 million. //2012//

/2013/ There were 17,080 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2010/2011, at a cost of $89,131,153. While the total Medicaid deliveries have decreased by 17 percent over the past five years, the average cost per delivery has increased by 18 percent over that time period. //2013//

/2014/ There were 16,472 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2011/2012, at a cost of $85,340,816. While the total Medicaid deliveries have decreased by 17 percent over the past five years, the average cost per delivery has increased by 18 percent over that time period. //2014//

/2015/ There were 15,616 deliveries to undocumented immigrants paid by Medicaid in fiscal year 2012/2013, at a cost of $80,185,264. This is the lowest number of deliveries and the lowest cost over the past five years, representing a 5.2 percent decrease in the number of deliveries and a 6 percent decrease in costs compared to the previous year. ///2015///

The geography of Florida can also create challenges in both the delivery of services and the response to events or disasters. With a total area of 58,560 square miles, Florida ranks 22nd among states in total area, though 4,308 square miles are covered by water. Driving from Pensacola in the western panhandle to Key West at the southernmost point is nearly an 800 mile journey. The 1,197 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation.

With the threat of tropical depressions and hurricanes looming every summer, the Department of Health has published a Family Preparedness Guide for residents and visitors as a tool that includes items such as: a fill-in family plan for disasters and emergencies, steps for making a disaster supply kit, and facts about natural and man-made threats. The guide is posted on the department's website, and is available in English, Spanish, and Creole. Disaster preparedness was tested in 2004 when Florida was hit with four major hurricanes and a tropical depression within a two-month period.

Florida's shorelines are facing a more prolonged threat this year, the oil spill in the Gulf of Mexico. Oil from this ecological disaster is likely to have an adverse effect on tourism, commercial and recreational fishing, and the many businesses supporting or supported by those industries. Tourism is a $65 billion a year industry that directly employs over one million people in Florida, and any serious setback in tourism greatly reduces revenue needed to sustain government services and infrastructure.

Unemployment continues to be a concern in Florida. In March 2010, the unemployment rate in Florida was 12.3 percent, the highest rate since 1970 when records began. In April, the rate dropped to 12 percent, which was still considerably higher than the national rate of 9.9 percent. An unemployment rate of 12 percent means that 1.1 million residents of the state are currently unemployed and looking for work. Additional residents who have been unemployed long-term or who have given up on finding work are not included in that total. Many who become unemployed lose health insurance coverage for themselves and their families.

/2012/ In April 2011, the unemployment rate in Florida fell to 10.8 percent, the lowest level in 19 months. An unemployment rate of 10.8 percent means that 996,000 residents of the state are currently unemployed and looking for work. Florida still has one of the highest unemployment rates in the country and is substantially above the U.S. rate of 9 percent. //2012//

/2013/ In April 2012, Florida's unemployment rate fell to 9 percent. While this is still higher than the national rate of 8.2 percent, the gap between the state and national rate is closing. The state's unemployment rate is the lowest it has been since January 2009. While an estimated 836,000 in Florida remained unemployed, there were 7,328,700 jobs in Florida as of March 2012, up 89,800 from a year ago. //2013//

Like many states, Florida is facing ever-increasing Medicaid costs. For many indigent families and the working-poor, whose jobs offer salaries below the federal poverty level with no medical benefits, Medicaid is the sole source of health care coverage. Yet even those who qualify may have difficulty receiving care, as the number of providers who accept Medicaid does not keep up with service needs. The 2010 Florida Legislature introduced a bill that would have established a Medicaid Managed Care Program, requiring that all Medicaid recipients be assigned to an HMO. The legislation did not pass during the current session, but it did set the stage for possible Medicaid reform next year.

/2012/ During the 2011 session, the Florida legislature passed a bill establishing the Medicaid program as a statewide, integrated managed care program for all covered services. There is mandatory participation for most populations, with some populations excluded. The bill calls for competitive, negotiated selection of qualified managed care plans that meet strict selection criteria, with a limited number of plans to ensure stability but allow significant patient choice. There are over 2.9 million Medicaid enrollees in Florida, and 1.9 million are currently enrolled in some type of managed care. Estimated Medicaid spending for fiscal year 2011-12 is $20.3 billion, or about $7,000 per recipient. Over half the childbirths in Florida are paid for by the Medicaid program, and 27 percent of Florida children are covered by Medicaid. //2012//

/2012/ If the legislation is implemented, local health departments that wish to continue serving Medicaid recipients will have to be providers within an HMO or a provider service network. Florida applied for a federal waiver to implement this version of reform. The state recently received a letter from the federal CMS indicating CMS had major concerns about a statewide Medicaid managed care system and many issues would have to be addressed before this type of expansion was approved. //2012//

/2015/ After approval from the Centers for Medicare & Medicaid Services, the Florida Agency for Health Administration developed and implemented the Statewide Medicaid Managed Care (SMMC) Program. The program is designed to: emphasize patient centered care, personal responsibility and active patient participation; provide for fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program; and implement innovations in reimbursement methodologies, plan quality and plan accountability. The Managed Medical Assistance (MMA) Program serves as the medical component of the SMMC. The MMA is comprised of several types of managed care plans: Health Maintenance Organizations, Provider Service Networks, and Children's Medical Services Network. Most Medicaid recipients must enroll in the MMA program. Many local health departments are already contracted with managed care plans

to serve their Medicaid enrollees. The Managed Medical Assistance Program is expected to be implemented statewide by August 1, 2014, ensuring that all local health departments will be able to continue to provide MCH and family planning services to Medicaid clients. //2015//

Addressing racial disparities in health outcomes continues to be an important focus of the Department of Health. In March 2005, the department hosted the 2005 Closing the Gap Summit, where national, state and local leaders, community-based organizations, health care professionals, and residents gathered to address this year's topic, Working Towards a Common Vision: Reducing Racial and Ethnic Health Disparities. The summit was held by the DOH Office of Equal Opportunity and Minority Health to address ways to decrease the morbidity and mortality rates in seven targeted diseases: cardiovascular, cancer, diabetes, HIV/AIDS, maternal and infant mortality, adult and child immunizations, and oral health care.

In an effort to address racial disparities in birth outcomes, the 2007 Florida Legislature passed a law creating a black infant health practice initiative. The purpose of the initiative was to review infant mortality in selected counties in order to identify factors in the health and social services systems contributing to higher mortality rates among black infants, and to produce recommendations on how to address the factors identified by the reviews. Broward, Dade, Duval, Gadsden, Hillsborough, Orange, Palm Beach, and Putnam counties were selected for the study. The quantitative analysis involved utilizing the Perinatal Periods of Risk process. This revealed that the highest rate of black feto-infant deaths occurred in the maternal health/prematurity period, which relates to a woman's health prior to pregnancy. As a result of the initiative, community action teams were formed in each county. The community action teams continue to address racial disparity issues within their communities. Recommendations from the study include: developing and implementing community education and outreach regarding racial disparity in infant mortality; focusing on strategies related to interconception care and education; focusing on infant safety including sleep position and safe sleep environment; working with providers on cultural sensitivity; reducing barriers to prenatal care; providing educational messages; reducing barriers to Medicaid; and improving father involvement during pregnancy and infancy.

Each year since 2002, the legislature has provided funding for Racial and Ethnic Disparity: Closing the Gap projects with a primary focus of addressing racial and ethnic disparity in the seven target areas listed above. Projects receiving funding are selected through a competitive bid process. Currently funded maternal and infant mortality projects focus on issues such as: access to prenatal care, education, advocacy, and public awareness; support and education to pregnant women and parenting women in at-risk black communities; early intervention services for Hispanic and Haitian women of childbearing age; education on effects of infections on preterm labor; identification of conditions associated with poor birth outcomes in black women, and maternal health risk factors with strategies designed to increase physical activity and improve eating habits.

In state fiscal year 2008/2009, six maternal and child health projects were awarded a total of $831,693 in Reducing Racial and Ethnic Health Disparities, Closing the Gap Act funding. For state fiscal year 2009/2010, six projects were awarded a total of $683,905. Maternal and infant mortality services promote good health before pregnancy (preconception care). Supports include community outreach and education; individual health risk screens; healthy lifestyle education; and medical referral and follow-up for women at risk for preterm labor and poor birth outcomes. Three projects focus on the health risks of women of African-American descent; two projects focus on both African-American and Hispanic women; and a new project provides "Promotoras" (community leaders as lay health workers) for Hispanic women in five farm worker communities, spanning seven Florida counties.

/2012/ For state fiscal year 2010/2011, six maternal and child health projects were awarded a total of $604,933. //2012//

/2012/ On April 14, 2011, the Office of Minority Health hosted Minority Health Education Day at the Capitol, to help educate legislators and raise awareness of the specific health needs of minority populations. //2012//

/2014/ In honor of Black History Month, the Office of Minority Health sponsored a number of activities during February 2013. Activities included a Culture Day in the park with health exhibitions and health screenings. A statewide webinar entitled Sickle Cell Disease was held that included a presentation on sickle cell disease by Maria Amanza, M.D. and a personal testimony on living with sickle cell disease by Mrs. Linda Mason. Florida's Surgeon General, John Armstrong, hosted a symposium at Florida International University entitled "Health Equity in Florida: Beyond Diversity and Promotion of Healthy Lifestyles." The purpose of the symposium was to bring a panel together to begin a conversation on addressing health equity. //2014//

/2014/ In recognition of National Black HIV/AIDS Awareness Day on February 7, the HIV/AIDS program encouraged community-based organizations, faith-based organizations, and local health departments from across the state to conduct educational and outreach activities, HIV testing and many other special events that will empower and mobilize Black communities in the fight against HIV/AIDS. The program also conducts similar activities each October 15 in recognition of National Latino AIDS Awareness Day. Many additional Department of Health activities, conferences, and initiatives address the need to reduce racial and ethnic disparities in the incidence of HIV/AIDS. Examples include, but are not limited to: Man Up Community Mobilization Meetings; Sistas Organizing to Survive (SOS), a grassroots mobilization of Black women in the fight against HIV/AIDS; Florida's faith-based initiative; a statewide minority media campaign; collaboration with the NAACP to address HIV/AIDS disparities among Blacks; Building Organizational Proficiency Projects; and the Targeted Outreach for Pregnant Women Act (TOPWA), which identifies high-risk minority pregnant women through outreach and links them with prenatal care and other services. //2014//

/2014/ As part of a National Minority Health Month observance, the department sponsored a live webinar panel discussion entitled "Ethnic Diversity and Cultural Competency in Cancer Care." The purpose of the discussion was to share, and raise awareness of the need for standards or guidelines for delivering culturally competent services to increasingly diverse patients and families. //2014//

To help address the needs of American Indians in Florida, the Department of Health formed an American Indian Advisory Council. This advisory group is part of the Minority AIDS Network and is comprised of six American Indian representatives from across the state. The council is led by an Elder and includes members with HIV/AIDS program experience, general medical experience, counseling in drug and alcohol abuse, and a leader in tribal dance, as we understand dance is an important part of religious and holistic healing ceremonies. This council will serve as part of our massive effort to address HIV/AIDS disparities among all racial/ethnic minorities. They will bring the voices of the Native American community together in an advisory role to discuss and address issues they are facing in providing HIV prevention and care services to their communities.

The council voted to keep their focus on HIV education and cancer prevention at this time. The council is interested in addressing other needs as well, but there are trust and cultural tradition issues that must be addressed first. It is hoped that a Tribal Consultation to be held sometime in the summer of 2010 will allow the department to establish further trust and bonds, and gain a better understanding of the health needs of this vast and divergent population. The 2000 U.S. Census counted over 117,000 American Indians in Florida, although community leaders feel that estimate is much too low. With more than 581 different tribes, bands, and clans in the state, addressing the various cultural needs can be a challenge, but the effort is an important one, as we work to help improve the lives of a population that is so important to the heritage of our state and nation.

/2015/ The goal of the American Indian Health Advisory Committee (AIHAC) has expanded to include developing strategies to eliminate health disparities among American Indian populations, strategizing training needs for American Indian communities, identifying gaps in the existing healthcare delivery systems and developing strategies to address these gaps, and facilitating partnerships that improve the health of American Indians. The committee consists of 15 representatives from Tribes and stakeholders serving American Indian communities. Through a partnership and resources provided by the Department of Health Office of Minority Health, the AIHAC has the ability to hold monthly meetings and conduct business at no cost to the AIHAC. //2015//

/2015/ The 2010 U.S. Census population estimates there are 162,562 American Indians and Alaska Natives living in Florida, representing approximately 0.5 percent of Florida's total population. The leading causes of death in the American Indian and Alaska Native populations are heart disease, cancer, and accidents (unintentional injuries). //2015//

/2014/ In honor of American Indian and Alaska Native Heritage Month, the Office of Minority Health and the American Indian Advisory Council presented several statewide webinar presentations during November 2012. Topics included diversity within the American Indian population in Florida and information on health disparities. //2014//

/2015/ In honor of American Indian and Alaska Native Heritage Month, the Office of Minority Health and the American Indian Advisory Council held two statewide webinar presentations during November 2013. The presentations were entitled "Strategies to Bring Health Services to Florida's Native American Peoples" and "American Indian Cancer Needs Assessments through Participatory Research of Florida." //2015//

Preventing obesity is another major issue for the department. The Healthy Communities, Healthy People (HCHP) program provides health promotion activities in each of Florida's 67 counties. One of the primary objectives is to increase healthy eating habits and physical activity among people of all ages. They provide technical assistance and support for local Healthy Start initiatives geared toward pregnant women and infants. We are discussing the potential to provide Chronic Disease Self-Management programs to women postnatally, possibly through the Centering Pregnancy format for prenatal care.

/2013/ The 2012 Legislature passed a bill calling for the reorganization of the Department of Health and a realignment of programs. One section of the bill ended the Healthy Communities, Healthy People program. //2013//

The department works closely with the Department of Education to provide technical assistance and resources to schools to support their wellness efforts. We also contract with four school districts to provide district wellness coordinators who establish and support wellness programs for district school employees. This models healthy behavior in the school setting and provides opportunities for increased physical activity and healthy eating to pregnant women within the school system. The HCHP staff in 10 counties also support a Robert Wood Johnson Foundation grant that focuses on childhood obesity prevention as a model project for community mobilization.

The Hispanic Obesity Prevention and Education Program (HOPE) was developed to provide nutrition education and obesity information geared to the Hispanic population, including women of childbearing age. The online portion of the project remains active although the program is no longer funded.

In an effort to address adolescent issues, the department created the Positive Youth Development Program in June 2009. The purpose of the program is to enhance the skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations throughout Florida. The program provides a network of community-based support

to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. In the first year, the program provided eight grants to local health departments to deliver positive youth development programs and activities in their communities. Positive Youth Development sponsored programs reinforce positive attitudes, healthy behaviors and activities, and reduce risk-taking behaviors, such as sexual activity, substance abuse, suicide and behaviors that increase risk of unintentional injury and chronic disease. Since its inception in 2009, more than 4800 youth and 600 parents have been served through the program.

Priorities identified in the 2010 needs assessment are summarized in Section II C and discussed at length in the 2010 Florida Needs Assessment.

/2013/ A number of Florida's federal community health centers were recently granted a total of $21 million in funding through the Affordable Care Act. The money received this year is expected to help the centers serve 41,000 new patients in Florida. Federal community health centers provide a medical home for uninsured low-income clients. //2013//

/2013/ The 2012 Legislature passed a bill calling for the reorganization of the Department of Health. A section of the bill created a statute requiring that private providers offer information to women whose prenatal tests indicate a fetal diagnosis of Down syndrome or another developmental disability. As part of the bill, the department must develop a clearinghouse of information related to developmental disabilities, and make it available to providers for use in counseling pregnant women. An advisory council will be formed to assist in this task. The Infant, Maternal, and Reproductive Health Section will also coordinate with Children's Medical Services and the Agency for Persons with Disabilities to gather clearinghouse information. //2013//

/2014/ House Bill (HB) 1263 passed during the 2012 Florida Legislative Session requiring the Department of Children and Families (DCF) and Department of Health (DOH) to develop and implement a WIC electronic benefit transfer (EBT) system no later than July 2013. This also requires a parallel implementation of a web-based eligibility system necessary to assess participants and certify WIC EBT benefits. The implementation incorporates the first time introduction of EBT technology to 500,000 WIC Participants, 220 clinics and over 2,000 commercial grocery vendors in Florida. To meet the HB 1263 requirements, WIC EBT requirements were incorporated in the DCF acquisition for EBT processing services for SNAP and other cash benefits. The joint contracting process was highly successful and produced the very best cost per case month for WIC available in the nation today. Introduction of WIC EBT is extremely beneficial for the WIC participant, the authorized WIC grocer and the WIC Program. WIC EBT provides WIC participants with essential shopping flexibility to obtain the prescriptive foods throughout the month, thereby improving freshness of foods and enabling a more efficient pattern of consumption. WIC EBT eliminates extensive manual reviews and settlement procedures presently used under the paper check system garnering strong support from WIC grocers. One major vendor reported to the department's Surgeon General that WIC EBT implementation will reduce processing costs by 90 percent for that entire vendor chain. The WIC Program and taxpayer will realize significant benefits from EBT implementation. Vendor food products can be individually evaluated for price and availability continually. This provides the lowest possible food costs, allowing limited grant funding to extend benefits to the highest number of children up to the age of 5 years possible. In addition, the implementation of the new WIC data system along with EBT will streamline WIC operations creating efficiencies at the clinic and state level. //2014//

/2013/ In April 2011, the Department of Health and the Florida Association of Healthy Start Coalitions initiated a Healthy Start Redesign Process scheduled to conclude in March 2013. The goal of the redesign project is to increase delivery of effective, evidence-based services in order to better improve maternal and infant health outcomes for Florida residents. Major efforts during the two-year process include: review current literature and best practices nationwide that identify effective pregnancy, preconception, interconception, and infant support service practices; review and evaluate the Florida Healthy Start program components and services to assess which are

research-informed and evidence-based; develop a comprehensive plan for implementing redesign elements to ensure program quality and fidelity; identify key effective program elements, processes, and quality indicators; develop a modular evaluation of the redesign that can be implemented in phases; and propose the elements, process, and options for a coalition allocation methodology that promotes quality, fidelity, and productivity. //2013//

/2014/ In March 2013, the department completed the Healthy Start Redesign process and is currently in the implementation phase. During the first year of implementation, beginning July 2013, the Florida Association of Healthy Start Coalitions will begin training on the models selected; Prenatal Plus and Partners for a Healthy Baby. In the subsequent fiscal year, training will begin on the Parents as Teachers program. The redesign will use the results-based accountability performance measure framework which identifies two types of accountability: population level and performance. This framework will determine who was served, the amount of services provided, quality assurance measures, and client outcomes such as changes in knowledge, behavioral changes, and mother and infant outcomes. //2014//

/2015/ Effective July 1, 2014, as a result of action taken during Florida's 2011 legislative session, the implementation of the 1915b Waiver and SOBRA (MomCare) was moved from the Department of Health to the Agency for Health Care Administration (AHCA). AHCA will contract with an administrative services organization (ASO) representing all Healthy Start coalitions. The ASO will require the coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the Waiver and SOBRA services. Medicaid-eligible clients will be part of Florida's Medicaid Managed Care Plan. Each plan's programs and procedures shall include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with agency policies and the MomCare network. The plans must establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to WIC, and the Children's Medical Services program for children with special health care needs. The department will continue to be responsible for the Healthy Start Program components and the components of how Healthy Start is implemented have not changed. The agency will evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. Additional training for DOH and Healthy Start Coalitions will continue in order to better assist providers and clients with Medicaid enrollment processes. //2015//

/2015/ In order to assess the oral health status of third-grade children, the Public Health Dental Program collaborated with the department's school health program, local schools, and the Florida Dental Hygiene Association to complete the first statewide oral health surveillance project in February 2014. The project, which began in August 2013, was completed in a representative sample of 41 public schools across 18 counties. More than 20 teams of dental hygienists and recorders provided screenings to assess dental caries experience, evidence of dental sealants, and dental treatment needs of third-graders. The screening data will be used to provide data on the oral health status of third-graders to national organizations, to plan future school-based oral disease prevention initiatives, and to link children who need dental treatment to a dental provider and local community resources. The data report and results of this surveillance project will be available later in 2014. //2015//

/2015/ Last year, MCH block grant funding was allocated to local health departments with a dental facility, to secure existing electronic oral health records by way of a mirrored dental server and, if applicable, funding for dental software. The dental facility will focus on purchasing server replication software, dental software and dental software training, if necessary. The goal is to improve dental clinic efficiency by way of electronic oral health

records, increase the number of dental care services provided, and to improve oral health record accuracy and data collection. //2015//

/2015/ MCH block grant funding was also allocated to help establish a Sealant Pilot Program in a five county, geographically contiguous area. Criteria for the school-based sealant pilot project were a high percentage of children on the free and reduced lunch program and a region of the state where minimal or no dental services are being provided by the local health departments. The project will initiate a regional portable sealant program to provide dental sealants to school children for the prevention of dental disease. //2015//

/2015/ Additional block grant funding to local health departments allowed them to utilize the allocation on one or more of the following MCH priorities: unplanned or unwanted pregnancy and teen pregnancy prevention; reducing pregnancy associated mortality activities such as preconception health counseling,; or dental services. //2015//

/2015/ The department planned and implemented a number of health protection activities in January in recognition of national Birth Defects Prevention Month, 2014. Activities included the development and distribution of a press release on both the department's communications website and Facebook pages, and a number of "tweets" posted throughout the month to coincide with the theme "Birth defects are common, costly and critical." In addition, materials were disseminated to 23 local health departments that requested them, for distribution in their local clinics. Material included a brochure developed by the Florida Birth Defects Registry entitled "Before you know you're pregnant" that provides information on preconception care and folic acid, and folic acid magnets, both tools being made available in English and Spanish. Lastly, 21 local health departments requested and were provided a total of 384 cases of multivitamins with folic acid for distribution to women of childbearing age. If taken before and early in pregnancy, vitamins containing folic acid can prevent neural tube defects, serious birth defects of the brain and spine. The U.S. Public Health Services recommends that all women who could become pregnant get 400 micrograms of folic acid every day. This could prevent up to 70 percent of neural tube defects. Clients who receive vitamins will be educated on interconception planning and encouraged to take multivitamins with folic acid on a daily basis. The primary goal of the multivitamin distribution project is to facilitate greater awareness and consumption of folic acid in women of childbearing age. //2015//

/2015/ The department amended its contracts with the Healthy Start Coalitions to further address substance-involved pregnant women and substance-exposed newborns. Coalitions must form interagency agreements with the local health department, the local child protection team, providers of Healthy Start prenatal and pediatric care services, the local Children's Medical Services offices, Healthy Families, substance abuse treatment providers, hospitals and birth centers, and the Department of Children and Families and their contracted providers in order to appropriately address the needs of substance abusing clients. //2015//

/2015/ The department further amended coalition contracts to stress the importance of interconception care and counseling. The contract ensures both Medicaid and non-Medicaid clients receive at least a set minimum number of interconception care and counseling services per month. The purpose is to promote the use of family planning for baby spacing, encourage management of chronic diseases, and educate on the importance of maintaining positive health behaviors to prepare for a subsequent pregnancy. The contract requires that priority be given to any at-risk woman who has had a poor pregnancy outcome, or an infant adopted or removed from the home. //2015//

/2015/ Reproductive health planning, coupled with increased emphasis on reinforcing the life course perspective, is further enhanced during quality assurance visits to local health

departments by liaisons that cover both MCH and family planning issues. //2015//

/2015/ In May 2014, the Florida Department of Health in Sarasota County sponsored a regional immunizations workshop entitled Constructively Addressing Parental Vaccine Hesitancy. The purpose was to educate nurses on how to allay concerns and encourage parents to reconsider their requests for exemptions to having their children immunized, to address the growing threat to public health as it relates to vaccine hesitancy and the increasing number of parents requesting exemptions. Block grant funding was provided to secure professional videography services, to make a high-quality video of the training that will be placed on the TRAIN Florida website. This will allow nurses statewide to benefit from this training, receive CEUs, and help to deter a growing trend that threatens communal immunization against childhood diseases such as measles and pertussis. TRAIN Florida is the Department of Health's official learning management system, through which employees are educated on a number of topics. //2015//

/2015/ The Florida Department of Health is pursuing accreditation through the Public Health Accreditation Board (PHAB). The goal of national accreditation is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local and territorial public health departments across 12 essential domains. Florida, as an integrated public health agency, is seeking a single accreditation decision for the state office and all 67 local health departments. Phase 1 focusses on the State Health Office. All documentation has been submitted and reviewed by the PHAB. A two-day site visit was conducted on March 6-7, 2014 and the final PHAB site visit report is pending. Phase 2 focusses on the local health departments. Submission of key documents is almost complete. Training will be provided by the PHAB in advance of site visits to 20 local health departments. Florida is seeking to become the first state in the nation to achieve national accreditation as an integrated public health agency, through joint accreditation of the state health office and all of the 67 local health departments. A final decision by the PHAB is anticipated by September 30, 2014. //2015//

B. Agency Capacity

The State Title V agency's capacity to promote and protect the health of all mothers and children begins with Healthy Start. Healthy Start is the primary delivery system for preventive and primary care services for pregnant women, mothers and infants. Healthy Start helps pregnant women and infants obtain the health care and social support they need to reduce the risks for maternal and infant death and to promote good health and developmental outcomes. These efforts include not only assurance of access to health care, but also identification and intervention for psychosocial risks including incidence of domestic violence, substance abuse, potential child abuse, or neglect.

Healthy Start includes the Healthy Start Prenatal and Infant Coalitions, who have the legislative authority and responsibility to plan and develop improved local MCH service delivery systems. Through an allocation methodology developed at the state level, state and federal funding, including MCH block grant funding, is distributed to local Healthy Start coalitions to support infrastructure building and the provision of services to the MCH population. Healthy Start also includes universal risk screening for all pregnant women and infants, and care coordination services for eligible participants.

Other MCH projects include the Pregnancy Associated Mortality Review (PAMR) project and the Fetal and Infant Mortality Review (FIMR) project. The PAMR project is a population-based surveillance and selective state level case review process aimed at reducing the maternal mortality rate. The FIMR project is a community-based collaborative effort to establish a continuous quality improvement mechanism for communities that focuses not only on the medical aspects of prenatal and infant health care delivery systems, but also on the psychosocial,

environmental and structural processes that contribute to fetal and infant deaths, and simultaneously complement the community-based nature of the Healthy Start coalitions.

Additional capacity is provided through the DOH Bureau of Epidemiology, which includes: periods of risk analysis to look at the proportional contribution of various periods to fetal and infant mortality; environmental epidemiology, addressing factors such as lead poisoning; birth defects surveillance; and the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a continuing random survey of mothers of Florida newborns, designed to provide information about risk factors for adverse pregnancy outcomes and ill health in newborns.

/2015/ To address the important public health problem of Neonatal Abstinence Syndrome (NAS) in Florida, the 2012 Florida Legislature created the Statewide Task Force on Prescription Drug Abuse and Newborns to research the impact of prescription drug use and neonatal withdrawal. As a member of the task force, the Department of Health was charged with addressing the policy recommendation of adding NAS to the list of Reportable Diseases and Events. The department requested the assistance of the Nutrition Branch at the Centers for Disease Control and Prevention in the form of an Epi-Aid. The purpose of the Epi-Aid investigation is to assess the validity of Florida's linked birth certificate, infant death certificate, and hospital inpatient discharge data as a means of NAS passive surveillance and to describe the characteristics and infant feeding practices of NAS infants. The findings will help enhance understanding of the strengths and limitations of using these data sets for routine surveillance purposes and will potentially identify components of NAS surveillance in Florida that warrant improvement. //2015//

The Department of Health's 67 local health departments across the state provide a variety of direct services to the MCH population; however, more and more local health departments are working with community providers to ensure services are delivered, rather than providing the services themselves. These services vary throughout the state and may include pregnancy testing, HIV pretest and post-test counseling, prenatal care, family planning, immunizations, periodic health history and physical examinations, preconception and interconception education and counseling, laboratory screening tests for health indicators such as lead and anemia, developmental screening, risk assessment, provision of anticipatory guidance, accident prevention, and substance abuse prevention education.

Local health departments are responsible for ensuring students have access to quality health services that assess, protect and promote their health and ability to learn. The basic school health services provided to all public school students are: nursing and nutritional assessments; record reviews to ensure physical exam and immunization requirements are complete, and appropriate services are provided for any chronic or complex health conditions; first aid; medication administration; screening for vision, hearing, growth and development, and scoliosis; emergency health services for injuries or acute illness; health education classes; parent and staff consultations on student health issues; and consultation for placement of students in exception education programs. Comprehensive and Full Service school health programs provide a broad range of health and social services in addition to basic school health services, in schools with high numbers of high-risk and medically-underserved children. Comprehensive school health emphasizes prevention of high risk behaviors, pregnancy prevention, and support services for pregnant and parenting teens.

/2014/ As part of the reorganization of the Department of Health, the Division of Community Health Promotion was designated by the legislature in HB 1263 as the replacement for the Division of Family Health Services. This new name better describes the scope of programs and services within the division, and reflects a clearer focus on providing leadership and expertise to local communities, statewide partners and health professionals to support healthy lifestyles. The bureaus within the division now combine the agency's expertise in nutrition; infant, maternal and reproductive health; school and adolescent health; chronic disease prevention; and tobacco in

one organizational unit. The current scope of programs reflects a life cycle approach. This approach focuses on health and disease patterns across populations and over time, and improves service quality by eliminating barriers between programs, assuring consistent health messaging, leveraging the skills and talents of staff, and improving efficient allocation of resources. //2014//

The Florida Department of Health Children's Medical Services (CMS) program provides children with special health care needs (CSHCN), from birth to age 21, a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. The CMS system of care includes a network of services that range from prevention and early intervention programs to primary and specialty care programs, including long-term care for medically complex children. CMS enrollees may receive medical and support services through 21 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs.

The CMS Network (CMSN) serves as a managed care choice for Medicaid beneficiaries who must choose a managed care option. Families of Medicaid eligible children who meet the clinical screening criteria may choose CMSN as their provider. The legislature directed CMS to maximize federal Titles XIX and XXI funds for its salaried staff. The CMS Program obtained federal approval to draw down Title XIX funds as a result of administrative claiming. In addition to the two CMSN insurance products (funded by Title XIX and Title XXI, depending on the child's income level), CMSN also provides Safety Net services for CSHCN who are not eligible for either of the other funding sources. CMS is responsible for coordinating policy and procedures across departments that relate to children and youth for special health care needs and has responsibility for the Part C Program of the Individuals with Disabilities Education Act and for the newborn screening program.

/2015/ After implementation of Statewide Managed Care, CMS will serve as a non-risk Prepaid Inpatient Health Plan under the Medicaid Manage Assistance Program. The CMS Network Specialty Plan will be operational in the fall of 2014. //2015//

/2012/ More than 90 percent of parents are satisfied with CMSN doctors. A total of 82 percent report care plans were developed, 77 percent reported the care coordinators coordinated care with doctors and specialists, and 41 percent said the care coordinators coordinated with the children's schools. //2012//

/2013/ Ninety-two percent of parents are satisfied with their child's primary care physician. Eighty-one percent reported a care plan was developed, 76 percent reported that the care coordinators coordinated care with doctors and specialists, and 33 percent said the care coordinator coordinated with their child's school. //2013//

/2014/ Ninety-four percent of parents are satisfied with their child's primary care physician. Seventy-four percent reported a care plan was developed, 82 percent reported that the care coordinators coordinated care with doctors and specialists, and 36 percent said the care coordinator coordinated with their child's school. //2014//

/2015/ Ninety percent of parents are satisfied with their child's primary care physician. Seventy-eight percent reported a care plan was developed, 78 percent reported that the care coordinators coordinated care with doctors and specialists. //2015//

CMS has adopted the Maternal and Child Health Bureau's National Goals as its six program goals and created performance measures for each:

Goal #1: All children who are enrolled in CMS Programs and their families will partner in decision-making at all levels and will be satisfied with the services they receive.

Goal #2: All children who are enrolled in CMS Programs will receive coordinated, ongoing, comprehensive care within a medical home.

Goal #3: All children enrolled in CMS Programs and their families will have the resources to fund services within the guidelines of the CMS Program.

Goal #4: All children will be screened early and continuously assessed for emerging or changing special health care needs.

Goal #5: CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families.

Goal #6: Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.

Each CMSN enrollee is eligible to receive care coordination. The care coordinator is a critical link in the development of a medical home for the child and family. The integration of the six national goals into the CMS program goals, performance measures and CAP further enhances the care coordination activities by ensuring the provision of ongoing, coordinated and comprehensive care, within the context of a medical home.

/2012/ The CMSN served 95,668 children in 2009-10 and over 18,000 through the Early Steps (ES) Program. //2012//

/2013/ The CMSN served 107,861 children in 2010-11 and 26,021 with an active Individual Family Service Plan (IFSP) through the ES Program. //2013//

/2014/ The CMSN served 86,962 children in 2011-12 and 23,878 with an active IFSP through the ES Program. //2014//

/2015/ The CMSN served 82,551 children in FY 2012-2013 and 24,995 with an active IFSP through the ES Program. //2015//

/2012/ A Family Health Consultant (FHC) was hired in 2010 to collaborate and strengthen partnerships at the national, state, and local level. //2012//

/2013/ CMS employs and provides reimbursement to families to participate on state, federal, and local advisory boards, projects, and steering committees. //2013//

/2014/ The ES program employs a parent consultant and family resource specialist who ensure family input and involvement at the state level and local level. These parents are included in policy development and review, assist in quality assurance activities, training, participation in workgroups, and collaboration with other statewide family groups. The family resource specialist role includes providing information and support, training, dissemination of information, input into policy development, community resource development, service delivery evaluation, and family representation in local activities. //2014//

/2015/ Local Early Steps programs employ a minimum of 1.0 FTE Family Resource Specialist to ensure family involvement. CMS pays for the AMCHP family representative and supports annual conference attendance. Family members participate on Newborn Screening Advisory and on the Steering Committee for the Partners in Care program. Families are invited to participate on various workgroups held on various CMS programs. //2015//

/2013/ Children who are in the foster care program who are clinically eligible for the CMSN will be enrolled based on the local system of care agreements. //2013//

/2014/ CMS enrolls children in foster care who are clinically eligible. //2014//

/2015/ In May 2014, Medicaid Manage Assistance was implemented in Florida. The foster care children are now enrolled in a Child Welfare Plan. //2015//

The CMSN Title V Director is a member of the national medical home advisory council supported by the American Academy of Pediatrics. The state was awarded a five-year CHIPRA demonstration grant and one component is training and evaluation of medical homes for children with special health care needs.

/2012/ CMS Primary Care (PC) programs provide a medical home to CMS offering the full range of PC services as well as providing care coordination activities, parenting, safety and health education to enrolled families. The PC Program is a collaborative effort between state government, local pediatric physician groups, and community providers. Number of clients served in 2009-10 was 40,532. //2012//

/2013/ CMS PC programs served 38,925 children in 2010-11. //2013//

/2014/ CMS PC programs served 39,463 in 2011-2012. CMSN continues to support the CHIPRA projects. /2013//

/2015/ CMS PC programs served 29,404 children in 2012-2013. //2015//

In 2008, Senate Bill 988 / House Bill 793 called for the creation of a time-limited task force to address the needs of young adults with disabilities moving into adult health care systems in Florida. CMS led the establishment of a statewide task force created though a legislative initiative. The task force included members of stakeholders and state agencies in order to assess the need for health care transition services, develop strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other pertinent data.

/2012/ CMS contracts with the University of South Florida (USF) for the Florida Health and Transition Services (FloridaHATS) Program to collaborate with communities to develop local/regional health care transition coalition sites in Pensacola, Jacksonville, and Tampa. FloridaHATS has organized a Medical Advisory Committee, comprised of pediatricians, pediatric and adult specialty physicians, a representative from the Florida Pediatric Society and the Florida Medical Association that meets to discuss how to achieve successful health care transition outcomes. Health care transition and insurance information is available at www.floridahats.org. //2012//

/2013/ FloridaHATS continues to collaborate with the three established health care transition coalitions in Pensacola, Jacksonville, and Tampa and initiating discussions with physicians and other interested potential stakeholders in Ft. Lauderdale and Miami to develop coalitions. //2013//

The CMS Pharmacy Benefits Program (PBM) provides increased pharmacy access for families of CMS enrollees. CMS contracts with MedImpact Healthcare Systems, Inc. to link with national, regional, and locally owned pharmacies throughout Florida to assist with the processing of prescriptions and to decrease waiting time for prescription refills, improve evening and weekend coverage, and provide a toll-free help desk to answer questions.

CMS, in coordination with Medicaid, has established 10 Children's Multidisciplinary Assessment

Teams (CMAT) to provide cost containment, quality assurance, and utilization review for medically complex children receiving high cost, long-term medical services. CMAT functions through a multidisciplinary, inter-program, and inter-agency effort. Team members include the family and representatives from the CMS and ES Programs of the DOH, Child Welfare & Community Based Care of the Department of Children and Families (DCF), the Agency for Persons with Disabilities (APD), and the Medicaid Program of the Agency for Health Care Administration (AHCA), in addition to any other community based agencies that may be able to assist in the care of a child. CMS has lead responsibility to facilitate this collaboration.

/2012/ There were 1,146 CMAT clients served during FY 2009-2010. //2012//

/2013/ There were 1,168 CMAT clients served during FY 2010-11. //2013//

/2014/ There were 1,230 CMAT clients served during FY 2011-12. //2014//

/2015/ There were 1,111 CMAT clients served during FY 2012-13. //2015//

The DCFs Behavioral Health Network works in conjunction with CMS to address the behavioral health needs for children age 5 to 19 who are between 101 percent and 200 percent of the federal poverty level. Diagnoses covered include mood, psychiatric, or anxiety disorders; severe emotional disturbance; and substance dependence. Children who are eligible for Medicaid receive behavioral health services through Medicaid.

The Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the AHCA, CMS within the DOH, and the Child Welfare and Community Based Care (CBC) Program within the DCF. To be eligible for the MFC program, children must be under the age of 21, be identified as needing medically necessary services to meet their medical complex condition, be in the custody of the DCF, and be medically stable for care in the home setting. The MFC Program establishes and supervises the oversight and training of foster parents to provide MFC services for these children. Medical foster parents are Medicaid providers, child-specifically trained, and are responsible for performing most of the day to day functions necessary for the child's care. This program is a cost-effective alternative to hospitalization, long-term, in-home, private duty nursing, or skilled nursing facility placement. The program currently serves approximately 742 children per year.

/2012/ The MFC program served 712 children in 2009-2010. //2012//

/2013/ The MFC program served 711 children in 2010-11. //2013//

/2014/ The MFC program served 728 children in 2011-12. //2014//

/2015/ The MFC program served 686 children in 2012-13. //2015//

Florida's ES Program offers early intervention services to infants and toddlers from birth to 3 years of age with developmental delays or established medical conditions that place them at risk for developmental delay. Through 15 contracted local offices across the state, the goal of ES is to increase opportunities for infants and toddlers with disabilities to be integrated into their communities and to learn, play, and interact regularly with children who do not have disabilities.

/2012/ There were 44,860 enrollees in ES during calendar year 2010. //2012////

/2013/ There were 45,727 enrollees in ES during fiscal year 2010-11. //2013//

/2014/ There were 42,638 enrollees in ES during fiscal year 2011-12. //2014//

/2015/ There were 42,314 enrollee in ES during fiscal year 2012-13. //2015//

Florida's Newborn Screening (NBS) Program provides screening for all newborns for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. Florida screens statewide for 36 disorders. The primary goals of the program are: to ensure all newborns born in Florida are screened and testing is processed within two weeks of birth; to ensure all affected newborns receive appropriate confirmatory testing, counseling, and treatment as soon as possible; and to ensure all affected newborns are placed into a system of care in a timely fashion.

/2012/ Electronic birth registration and NBS information will be linked in 2011 to ensure accurate data and provide an accounting of each baby issued a birth certificate to receive a NBS test. In 2011, the Genetics and NBS advisory Council recommended Severe Combined Immunodeficiency (SCID) be added to Florida's panel of newborn screening disorders. //2012//

/2013/ Change in the goal referenced above, to ensure all newborns born in Florida are screened and testing is processed within one week of birth. Electronic birth registration and newborn screening information will be linked in 2012. Implementation of the SCID screening is scheduled to begin in the 2012-13 state fiscal year. //2013//

/2014/ Electronic birth registration and NBS information will be linked in 2013 to ensure accurate data. In 2012, the Genetics and NBS advisory Council recommended Critical Congenital Heart Disease (CCHD). SCID was added to Florida's panel of newborn screening disorders on October 1, 2012. //2014//

/2015/ In 2013 the Florida Legislature appropriated funds to support the implementation of CCHD. The blood specimen card was updated to include a section for hospitals to record CCHD results. Hospitals were surveyed in February 2014 regarding current CCHD testing protocols. Data system modifications for CCHD results entry and follow-up will take place summer 2014. NewSTEPs review took place February 2014. Online reporting of hearing screening results went live in June 2013 and a third of all birth hospitals were trained and registered. //2015//

The CMS Early Hearing Loss Detection and Intervention (EHDI) program promotes universal newborn hearing screening, effective tracking and follow-up as a part of the public health system, appropriate and timely diagnosis of the hearing loss, and prompt enrollment in appropriate Early Intervention services. EHDI links newborns to a medical home and strives to eliminate geographic and financial barriers to service access. A component specific to serving families of children with hearing loss has been established in the Part C ES program with ongoing emphasis on improving the number and quality of early intervention service providers.

The CMS Genetics Program provides genetic evaluation, diagnosis, and counseling for children with or at risk for having a genetic disorder. Services provided include initial and follow-up diagnostic and evaluation; genetic counseling; lab studies required for confirmation of genetic disorders; confirmatory testing for infants with abnormal test results for PKU and galactosemia; dietary consultation for treatment of PKU or galactosemia; and educational programs for CMS staff. The genetics telemedicine project enables a pediatrician and a University of Florida (UF) geneticist to communicate via two-way interactive video technology.

/2012/ In addition to PKU and galactosemia, the Program provides confirmatory testing and dietary consultation for infants with abnormal test results for Biotinidase and various metabolic disorders. Services are provided through a network of three Genetic Centers and CMS community based clinics. Centers are located at UF, University of Miami (UM) and USF. UM and UF offer genetic consultations via telemedicine with the CMS Network. //2012//

The Pediatric HIV/AIDS Program provides infants and children with HIV/AIDS access to a continuum of services through a network of seven Pediatric HIV Referral Centers and 10 CMS satellite clinics. Pediatric HIV Program services include evaluation, diagnosis, care coordination,

nutrition counseling, permanency planning, assistance with transportation, and other support services. Over 1,350 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic.

/2012/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 10 CMS satellite clinics. Over 1,000 infants and children received services at a Pediatric HIV Referral Centers or CMS HIV Satellite Clinics in FY 2009-10. //2012//

/2013/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 11 CMS satellite clinics. Over 1,000 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic in FY 2010-11. //2013//

/2014/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 11 CMS satellite clinics. Over 1,400 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic in FY 2011-12. //2014//

/2015/ The Pediatric HIV/AIDS Program provides services through a network of six Pediatric HIV Referral Centers and 11 CMS satellite clinics. Over 900 infants and children received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic in FY 2012-13. //2015//

CMS has partnered with the AHCA and Florida Hospices and Palliative Care to provide pediatric palliative care services to children with life-threatening conditions enrolled in CMSN. As the first publicly-funded palliative care program in the nation, the Partners in Care: Together for Kids (PIC:TFK) program provides palliative care from the time of diagnosis through the course of treatment. Services include pain and symptom management; patient and family counseling; expressive therapies; and respite, nursing and personal care. Services are provided to eligible CMSN children enrolled in the Title XXI program, and under the 1915(b) Managed Care Waiver, allowing palliative care services to be extended to children with Medicaid who have life-threatening conditions. PIC: TFK is in the fifth year of implementation serving over 1000 children since July 2005.

/2012/ During 2010-11, program sites expanded from seven to 14, providing services to over 1,100 children. //2012//

/2013/ 14 program sites serve approximately 500 children in 2011-12. //2013//

/2014/ During 2011-12, over 730 children were served in 14 program sites. //2014//

/2015/ During 2012-13, over 690 children were served in 14 program sites. //2015//

The DOH, CMS, Division of Prevention and Intervention, promotes the safety and well-being of children in Florida by providing specialized services to children with special health care needs associated with child abuse and neglect. The division consists of three units: the Child Protection Unit, the Prevention Unit, and the Special Technologies Unit.

/2014/ The Division of Prevention and Intervention and the CMS Network Division were combined to form the Division of Children Medical Services Program. /2014//

The CMS Child Protection Team (CPT) Program is a medically led, multidisciplinary program based on the concept that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children. CPTs supplement the assessment and protective supervision activities of the DCF, child protective staff at local sheriff offices, and other community based care providers in reports of child abuse and neglect. There are 25 teams throughout the state to provide specialized assessments and services to child victims, siblings, and their families. Services provided may include: medical diagnosis and evaluation, medical

consultation, forensic interviews of suspected child victims, specialized interviews of children and their family members, family psychosocial assessment, nursing assessment, psychological evaluation, multidisciplinary staffing, and expert court testimony. The CPTs handled 28,452 cases involving child victims and their families and provided 39,139 assessments.

/2012/ The CPTs handled 29,453 cases involving child victims and their families and provided 48,979 assessments. //2012//

/2013/ The CPTs handled 29,933 cases involving child victims and their families and provided 45,833 assessments. //2013//

/2014/ The CPTs handled 28,956 cases involving child victims and their families and provided 45,218 assessments. //2014

/2015/ The CPTs handed 30,247 cases involving child victims and their families and provided 80,405 assessments. //2015//

The CMS Telehealth Program works with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. CPT Telemedicine capabilities are now available at 17 service sites, which provided assessment for 378 children in 2009.

/2012/ CPT Telehealth services are available at 16 sites and 439 children were provided medical or other assessments via telemedicine technology. //2012//

/2013/ CPT Telehealth services are available at 14 sites and 437 children were provided medical or other assessments via telemedicine technology. Two sites that were funded by a grant were discontinued when the grant ended. //2013//

/2014/ CPT Telehealth services are available at nine sites and 667 children were provided medical or other assessments via telemedicine technology in 2011-2012. //2014//

/2015/ CPT Telehealth services are available at six sites and 550 children were provided medical or other assessments via telemedicine technology in 2012-2013. //2015//

The CMS Sexual Abuse Treatment Program (SATP) promotes the safety and well-being of children in Florida by providing specialized, comprehensive, multidisciplinary assessment and treatment services for children who have experienced sexual abuse, their siblings, and their non-offending caretaker. SATPs work with child protective investigators and CPTs. Community agencies, individuals, and other professionals may also make direct referrals. The SATPs may provide therapeutic services for children (and their non-offending family members) who have been the victim of interfamilial sexual or physical abuse or child on child sexual abuse. The number of SATP providers are 17; with all areas of the state having an area provider. The SATP served 5,716 child victims, their siblings and families in 2007-2008.

/2012/ The SATP served 9,138 child victims, plus 6,557 of their siblings and parents/caregivers in 2009-10. //2012//

/2013/ The SATP served 9,781 child victims plus 6,419 siblings and parents/caregivers in 2010-11. //2013//

/2014/ The SATP served 9,801 child victims plus 4,804 siblings and parents/caregivers in 2011-2012. //2014//

/2015/ The SATP served 8,147 child victims plus 4,379 siblings and parents/caregivers in 2012-2013. //2015//

The CMSN works with the Special Technologies Unit to maintain the CMS contracted program with the UF pediatric endocrinology staff that provides telehealth services for CMS enrollees with diabetes and other endocrinology diagnoses served by the Daytona Beach CMS area office. The use of two-way interactive video technology has proven to be an effective way of ensuring the availability of expert medical services to outlying rural areas. Other initiatives include: a partnership with the Institute for Child Health Policy at the UF to refer CSHCN who are seen at three of the state's community health centers to a CMS office for enrollment; nutritional, neurological, and orthopedic consults for CMS enrollees in Ft. Pierce, West Palm Beach, and Ft. Lauderdale; craniofacial team meetings; various educational presentations between CMS area offices; and numerous administrative and consultative meetings with CMS staff. Some CMS offices are beginning to work with the UM to develop teledermatology clinics as well.

/2012// The UF provide pediatric endocrinology clinics, genetics evaluations, and counseling to CMS enrollees in other locations of the state. The UM provides dermatology, neurology, genetics, and nutritional counseling via telemedicine for CMS enrollees who live in the Ft. Lauderdale, West Palm Beach, and Ft. Pierce area. //2012//

/2013/ CMS Area Offices continue to provide specialty services using telemedicine technology. Clinics include endocrinology, genetics, nutritional counseling, dermatology, and neurology. //2013//

/2015/ CMS Area Offices continue to provide specialty services using telemedicine technology. Clinics include endocrinology, genetics, nutritional counseling, dermatology, and neurology. //2015//

CMS oversees the statewide Poison Information Center Network. Poison prevention and management information is provided 24 hours a day through a toll-free number. The centers provide access to poison information, triage of the potentially poisoned patient, collection of pertinent data, professional consultation for health care providers, and professional and consumer education. During fiscal year 2007-08, the network handled 191,494 calls, provided 6,395 consults, provided education services to 1,766 community programs, 372 professional events, and participated in 824 health fairs or other special events. Over 500,000 pieces of informational materials and 78 media/public relation activities were provided.

/2012/ There are three nationally certified Poison Information Centers that are overseen by CMS. During fiscal year 2009-10, the network handled 193,929 calls, provided 7,310 consults. The network provided education services to 1,223 community programs, 157 professional events, and participated in 369 health fairs or other special events. Over 568,000 pieces of informational materials and 111 media public relation activities were provided. //2012//

/2013/ During 2010-11, the network handled 186,153 calls provided by 8,947 consults. The network provided education services to 1,410 community programs, 308 professional events, and participated in 806 health fairs or other special events. Over 504,038 pieces of informational materials and 117 media public relations activities were provided. //2013//

/2014/ During 2011-12, a total of 176,073 calls were handled by 7,200 consults. Education services were provided to 1,229 community programs, and 453,570 pieces of educational materials were distributed. //2014//

/2015/ During 2012-13, a total of 154,965 calls were handled by 8,139 consults. Education services were provided to 1,879 community programs and over 359,793 pieces of educational materials were distributed. //2015//

CMS has responsibility for the Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) information program. The brochures and educational information are required to be given to parents of every newborn prior to hospital discharge. This initiative includes conducting training

for hospital nurses to provide Coping with Crying education and coping strategies to new parents prior to discharge.

/2012/ In year 2009-10, over 380,000 copies of the Coping with Crying brochure were distributed. Training was provided to parents of newborns in 23 facilities. //2012//

/2013/ In 2010-11, over 181,950 copies of the Coping with Crying brochure were distributed. Training was provided to parents of newborns in 143 facilities. //2013//

/2014/ In 2011-12, over 247,000 copies of the Coping with Crying brochure were distributed to 226 facilities. //2013//

/2015/ In 2012-13, over 325,840 copies of the Coping with Crying brochure were distributed to 307 facilities. //2015//

The basic statutory authority for MCH is Section 383.011, Florida Statutes, Administration of Maternal and Child Health Programs. The statute authorizes the Department of Health to administer and provide MCH programs, including the WIC program and prenatal care programs. This statute also designates the Department of Health to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds. Other statutes related to the MCH program:
Section 409.810, F.S., establishes Florida KidCare.
Section 154.01, F.S., authorizes the Department of Health to operate primary care programs through the local health department delivery system, establishing a system of comprehensive integrated care.
Section 91.297, F.S., provides the authority for the Department of Health to implement a comprehensive family planning program.
Section 381.0056, F.S., delineates the joint responsibilities and cooperative efforts the Department of Health and the Department of Education have in implementing the school health services program.
Section 381.0057, F.S., establishes comprehensive school health services to provide health services in the schools, to promote the health of students and to reduce teenage pregnancy.
Section 381.0052 (e), F.S., the Public Health Dental Program Act, makes available dental preventive and educational services to all citizens and treatment services to indigent persons.
Section 383.014, F.S., authorizes screening and identification of all pregnant women entering into prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity.
Section 383.216, F.S., establishes prenatal and infant coalitions for the purpose of establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Related statutes include statutory authority and mandates pertaining to: screening of infants for metabolic and other hereditary and congenital disorders; infant hearing impairment; perinatal and neonatal services; child protection; sexual abuse treatment; developmental evaluation and intervention; hematology; oncology; poison centers; and parent support and training programs. Other statutes related to the Children's Medical Services Program:
Section 383.144, F.S., Infant Hearing Impairment Program.
Section 383.15-.21, F.S., Regional Perinatal Intensive Care Centers Program.
Section 383.215, F.S., Developmental Intervention and Parent Support and Training.
Sections 415.5055, 415.5095, F.S., Child Protection Teams.
Section 402.24 F.S., Recovery of Third Party Payments for Medical Services.
Chapter 385, F.S., Chronic Disease, Hematology/Oncology Care Centers Program.
Section 395.038, F.S., Regional Poison Control Centers.

Chapter 187, F.S., State Comprehensive Plan.
Section 409.905, F.S., Early and Periodic Screening, Diagnosis and Treatment Services.
Chapter 411, F.S., Florida Prevention, Early Assistance and Early Childhood Act.
98.282, Florida Laws, Healthy Start Act.
Section 383.14, F.S., Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 383.145. F.S., Newborn and infant hearing screening.

C. Organizational Structure

The Florida Department of Health is directed by the State Surgeon General, who answers directly to the Governor. The Surgeon General is responsible for overall leadership and policy direction of the department. The Surgeon General is assisted by the following key staff:

Chief of Staff: oversees the offices of Communications, Legislative Planning, and Performance and Quality Improvement.

Deputy Secretary: oversees many of the department's key support functions including the Division of Administration, which includes the bureaus of Budget and Revenue Management, Finance and Accounting, General Services, and Personnel and Human Resource Management; the Division of Disability Determination; the Office of Information Technology; and the Division of Medical Quality Assurance.

Deputy Secretary for Statewide Services: provides oversight and direction to the state's local health department directors and administrators who are responsible for the 67 local health departments; and the Division of Public Health Statistical and Performance Management.

Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services: oversees the divisions of Children's Medical Services; Community Health Promotion; Disease Control and Health Protection; Emergency Preparedness and Community Support; as well as the 22 CMS Regional/Area Offices and the Office of Minority Health.

/2012/ The 2010 Florida Legislature passed a bill requiring the Department of Health to conduct a comprehensive evaluation and justification review of its divisions and programs. Among many identified opportunities for improvement, two in particular stood out: the need to establish a clear mission and the need to establish and cultivate a culture of accountability and performance excellence. The evaluation will help the Department of Health identify health priorities and focus efforts and resources on towards those priorities with the highest potential for improving health status. //2012//

/2013/ As part of the Department of Health reorganization bill passed by the 2012 Florida Legislature and signed into law by Governor Rick Scott, the Division of Family Health Services is now known as the Division of Community Health Promotion. The Bureau of Family and Community Health is now known as the Bureau of Family Health Services. //2013//

The Florida Department of Health is responsible for the administration of programs carried out with allotments under Title V. The majority of these programs fall within the auspices of the Division of Community Health Promotion and the Division of Children's Medical Services. The directors of these two divisions play an important role in the Title V direction, and high-level staff within these divisions serve as the primary Title V contacts for the state,.

/2015/ Kris-Tena Albers, ARNP, CNM, Chief of the Bureau of Family Health Services, serves as the Title V MCH Director. Charlotte Curtis, RN, BSN, CPA, Acting Division Director for Children's Medical Services, serves as the Title V CSHCN director. //2015//

The Division Director of Community Health Promotion provides leadership, policy, and procedural

direction for the division, which includes the bureaus of Child Care Food Programs, Chronic Disease Prevention, Family Health Services, Tobacco Free Florida, and WIC Program Services.

The Bureau of Family Health Services is responsible for many of the Title V activities related to pregnant women, mothers, and infants; and children. The Bureau Chief directs the offices of Infant, Maternal, and Reproductive Health (IMRH); Child and Adolescent Health; and Adult and Community Health.

/2015/ The Bureau of Family Health Services has undergone recent reorganization. Programs and sections within the bureau include the Public Health Dental Program; the Preventive Services and Quality Management Section; the Maternal and Child Health Section; and the School, Adolescent, and Reproductive Health Section. //2015//

Programs within Infant, Maternal, and Reproductive Health (IMRH) include Title V, Family Planning (Title X), Healthy Start, Pregnancy Associated Mortality Review, and Fetal and Infant Mortality Review.

/2015/ IMRH is now known as the Maternal and Child Health Section (MCH). MCH includes the Healthy Start Program; the Maternal and Child Health Program, which includes among other responsibilities Pregnancy Associated Mortality Review and Fetal and Infant Mortality Review; and the Grants/Data/Budget/Procurement Team, which has primary responsibility for coordinating and collating information for the Title V Block Grant application, managing the MCH Block Grant, and providing program guidance based on monitoring the performance indicators and conducting data analysis. The Family Planning Program is now part of the School, Adolescent, and Reproductive Health Section. //2015//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Following is a description of senior level management employees in lead positions.

/2012/ Governor Rick Scott appointed H. Frank Farmer Jr., MD, PhD, to serve as Florida State Surgeon General. Dr. Farmer began his tenure at the Department of Health on April 4, 2011. His work in the field of medicine includes his role as the Medical Director for Blue Cross/Blue Shield of Florida; private practitioner at East Volusia Internal Medicine Associates; and President of Endeavors Medical Group. Most recently, he was the Medical Director for Covance (Medical Research) in Daytona Beach, Florida. Dr. Farmer has served on the Florida Medical Association (FMA) Board of Governors and Florida Board of Medicine and has also served as FMA President and Chair of the Board of Medicine. //2012//

/2013/ Dr. Farmer is no longer with the Department of Health. //2013//

/2013/ John H. Armstrong, MD, FACS, was appointed by Governor Scott as Florida State Surgeon General and Secretary of Health on April 27, 2012. Previously, he was Chief Medical Officer of the USF Health Center for Advanced Medical Learning and Simulation; Surgical Director of the USF Health American College of Surgeons Accredited Education Institute; and Associate Professor of Surgery, Department of Surgery, University of South Florida (USF) Morsani College of Medicine. He previously served as the Trauma Medical Director at Shands Hospital at the University of Florida Medical Center, and was a 2011 Exemplary Teacher at the University of Florida College of Medicine. //2013//

Ana M. Viamonte Ros M.D., M.P.H., serves as the State Surgeon General of the Florida Department of Health. She is the first woman and the first Cuban American to lead the department. She came to DOH from Armor Correctional Health Services, where she worked to

organize and monitor the health care delivery services in Florida's correctional institutions, and also oversaw the development of medical discharge programs.

/2012/ Dr. Viamonte Ros is no longer with the Department of Health. //2012//

Robert Siedlecki, Jr., was appointed Chief of Staff for the Florida Department of Health in March 2009. He previously served six years in the federal government with two agencies, at the Department of Health and Human Services as Special Assistant to the Assistant Secretary for Children and Families, and the Department of Justice as Senior Legal Counsel to the Task Force for Faith-Based and Community Initiatives.

/2012/ Mr. Siedlecki is no longer with the Department of Health. The Chief of Staff position has not been filled. //2012//

/2014/ Kim Barnhill, M.S., M.P.H, was named as Chief of Staff for the Florida Department of Health in July 2012. Her previous experience with the department includes overseeing dual local health departments, directing preventive dental programs for over three dozen counties, and serving as the Director of Statewide Services. In her duties as Chief of Staff, Ms. Barnhill also supervises the Offices of Legislative Planning, Communications, and Performance Improvement. //2014//

Kim Berfield was named the Deputy Secretary for the Florida Department of Health in February 2007. Prior to joining the Department of Health, she served four terms as a representative in the Florida House. She served in numerous positions during those terms, including Chairman of the Insurance Committee and Chairman of the Republican Conference.

/2012/ Ms. Berfield currently serves as the Deputy Secretary for Policy and Advocacy. //2012//

/2013/ Ms. Berfield is no longer with the Department of Health. //2013//

Shairi R. Turner, M.D., M.P.H., serves as both the Deputy Secretary for Health and the Director of Minority Health. Prior to joining the Department of Health, she served as the first Chief Medical Director in the Florida Department of Juvenile Justice, where she was responsible for assisting that department with the provision and oversight of quality medical, mental health, substance abuse, and developmental disability services.

/2012/ Dr. Turner left the department on June 30, 2012. The department is currently recruiting a new Deputy Secretary for Health. //2012//

/2013/ Steven Harris, M.D. M.Sc., currently serves as the Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services (CMS). Divisions under his leadership include the Division of Community Health Promotion and the Division of CMS Network, and he also oversees the CMS Clinics, giving him ultimate responsibility for Title V activities. Dr. Harris also oversees the Division of Emergency Preparedness and Community Support and the Division of Disease Control and Health Protection. //2013//

/2014/ Dr. Harris is no longer with the Department of Health. Celeste Philip, M.D, M.P.H., is presently serving as the Interim Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services. In these roles, Dr. Philip provides leadership over the Division of Children's Medical Services and the 22 CMS Regional Offices; the divisions of Community Health Promotion, Disease Control and Health Protection, and Emergency Preparedness and Community Support; and the Office of Minority Health. //2014//

/2015/ Dr. Phillip was officially named Deputy Secretary for Health and the Deputy State Health Officer for Children's Medical Services, and no longer serves in an interim role. //2015//.

Michael Sentman, Assistant Deputy Secretary for Health, is responsible for the oversight and direction of the 60 local health department directors and administrators responsible for the 67 local health departments in Florida. He has over 13 years of experience at the local health department level, 10 of which was as an Administrative Services Director, and over five years at the department level.

/2013/ Mr. Sentman has assumed a position with the Florida Department of Health in Gadsden County. //2013//

/2013/ Robert "Sterling" Whisenhunt has been named the Assistant Deputy Secretary for Health. He serves as the Statewide Services Director and is responsible for the oversight and provision of direction to the 60 local health department Directors and Administrators responsible for the 67 local health departments. //2013//

/2014/ C. Meade Grigg has been named as the Deputy Secretary for Statewide Services. He serves as the Statewide Services Director and is responsible for the oversight and provision of direction to the 60 local health department Directors and Administrators as well as the Division of Public Health Statistics and Performance Management. //2014//

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 25 years of experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

/2012/ Dr. Chiaro is no longer with the Department of Health. Due to changes in the department's structure, there are no plans to fill or continue this position. //2012//

The Title V programs are distributed among the Division of Family Health Services and Children's Medical Services Program, which has two divisions. As of May 2010, there are 30 central office staff in the Division of Family Health Services, Bureau of Family and Community Health, who perform duties for Title V funded programs. There are approximately 2,000 local health department staff members who create the local infrastructure for Title V funded programs. The senior level management employees include: Annette Phelps, A.R.N.P., M.S.N., Division Director for Family Health Services, State Title V Director and Terrye Bradley, M.S.W., Bureau Chief, Family and Community Health. Capacity is also provided through the 30 Healthy Start coalitions covering 65 of the 67 counties in Florida. Department of Health local health departments serve as the Healthy Start coalition in the other two counties. Additional capacity is provided through partnerships with the private sector, the public sector, state government, local governments, community alliances, and maternal and child health care providers, and through linkages with state and national work groups and associations that provide capacity building by enhancing current competencies for staff and technical assistance.

Annette Phelps, A.R.N.P., M.S.N., has served as the Division Director for Family Health Services since 2002. Prior to that, Ms. Phelps served as the Bureau Chief for Family and Community Health, and was the Executive Community Health Nursing Director in the Office of Maternal and Child Health (now known as Infant, Maternal and Reproductive Health). Before joining the Central Office staff in 1989, Ms. Phelps worked for a number of years in local health departments.

/2013/ Ms. Phelps is no longer with the Department of Health. //2013//

/2013/ On April 30, 2012, Betsy Wood, B.S.N., M.P.H., was named Interim Director of the Division of Community Health Promotion, the division formerly known as Family Health Services. Ms. Wood has a vast array of experience within the department, including work within Children's Medical Services and as the unit director of the former Maternal and Child Health Office, now

IMRH. She most recently served as Interim Director of the Division of Health Access and Tobacco and also serves as Chief of the Bureau of Chronic Disease Prevention and Health Promotion. //2013//

/2014/ Ms. Wood has been formally named as the Director of the Division of Community Health Promotion. //2014//

Katherine Kamiya, M.Ed., serves as the Assistant Division Director for Family Health Services. She joined the division in 2007, bringing over 25 years of experience in direct services, administration, and executive leadership with addressing the needs of at-risk children and families. In this role, Ms. Kamiya also coordinates orientation, training and professional development activities, as well as legislative bill tracking for the Division of Family Health Services.

Terrye Bradley, M.S.W., joined the Department of Health in 2002 to become the Bureau Chief of the Bureau of Family and Community Health. Ms. Bradley's prior experience includes serving as the Chief of Volunteer Services in the Department of Juvenile Justice, and as the Chief Operating Officer for an eight-site Community Health Center. She also worked several years as an administrator within a community-based hospice program.

/2013/ Ms. Bradley is no longer with the Department of Health. //2013//

/2014/ Kris-Tena Albers, A.R.N.P., C.N.M., M.N., now serves as the Chief for the Bureau of Family Health Services. Ms. Albers formerly served as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Section. //2014//

William M. Sappenfield, M.D., M.P.H., joined the Division of Family Health Services in 2005. Dr. Sappenfield serves as the director of the MCH Practice and Analysis Unit. The main role of the unit is to enhance and support policy and program decision-making through surveillance, health monitoring, epidemiology investigations, evaluation, training, and capacity building.

/2013/ Dr. Sappenfield is no longer with the Department of Health. //2013//

Kris-Tena Albers, A.R.N.P., C.N.M., M.N., joined the Division of Family Health Services in 2008 as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Section, which includes programs related to maternal and infant health and the Family Planning Program. Ms. Albers experience includes work within the department in the Office of Public Health Preparedness and in Public Health Nursing. She has also worked as a certified nurse midwife, an adjunct instructor for nursing students, and in nursing positions focusing on women's health.

Additional capacity within the Infant, Maternal and Reproductive Health Section includes the following personnel:

Margaret Rankin, R.N. B.S.N., serves as the leader of the Family Planning Program, and has worked in Family Health Services since 1998.

/2014/ Margaret Rankin, R.N. B.S.N., was named as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Section in January 2013. Ms. Rankin oversees the statewide Healthy Start and Family Planning programs, as well as all maternal and child health initiatives. //2014//

/2015/ Ms. Rankin is no longer with the Department of Health. //2015//

Carol Scoggins, M.S., joined Infant, Maternal, and Reproductive Health in October 2009, and serves as the Program Administrator for the Maternal and Child Health team, and has worked in

Family Health Services since 2004.

/2015/ In March 2014, Ms. Scoggins was named Section Administrator of the Maternal and Child Health Section, replacing Margaret Rankin in what was formerly known as the Infant, Maternal, and Reproductive Health Section. //2015//

/2013/ Christina Canty, M.P.A., C.P.M., joined Infant, Maternal, and Reproductive Health in June 2012 as a Program Administrator for the IMRH team responsible for budget, procurement, grants, and data analysis. //2013//

Karen Coon, A.R.N.P., M.S.N., joined Infant, Maternal, and Reproductive Health in July 2010 as the leader of the Healthy Start contracts team, and has previous experience working in the bureau of Family and Community Health as well as CMS.

/2014/ Karen Coon is no longer with the Department of Health. Ms. Coon was replaced by Nita Harrelle who joined the Infant, Maternal, and Reproductive Health Section in December 2012 as the Program Administrator/Supervisor for the Healthy Start Contract Management Team. Her previous experience with the department includes working in the Bureau of Communicable Disease as the Perinatal HIV Prevention Coordinator, managing the Targeted Outreach for Pregnant Woman Act (TOPWA) program. //2014//

As of May 2011, there were 73 central office staff members in the Children's Medical Services Program. The CMS Network Division performs the duties for the Title V children with special health care needs component. There were 671 out-stationed staff members in the 21 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, Marybeth Vickers, R.N., MSN., Chief for CMS Network Operations Bureau, and Peggy Scheuermann, M.Ed., Deputy Division Director for CMS Prevention and Early Interventions Programs.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 30 years of experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

/2012/ Dr. Chiaro is no longer with the Department of Health. //2012//

/2014/ During the 2012 legislative session, the Deputy Secretary position for CMS and the Division Director for CMS Prevention and Early Interventions Programs were eliminated. Due to this change, the Division of CMS Prevention and Early Intervention Program and the Division of Network and Related Programs were combined into the Division of Children's Medical Services Program, under the direction of one Division Director. Dr. Celeste Philip currently serves as Deputy State Health Officer for the CMS Program, as well as providing leadership for three other divisions and the Office of Minority Health. //2014//

Phyllis Sloyer, R.N., Ph.D., has served as the Division Director for Children's Medical Services since 1996 and is the Title V CSHCN Director. Prior to that Dr. Sloyer has served in several managerial positions in Children's Medical Services since 1979. She also served as Associate Director of the National Center for Policy Coordination at the Institute for Child Health Policy from 1990 to 1993 and has extensive experience in developing systems of care for CSHCN. She has also been recognized as Florida's Public Health Woman of the Year, has served as treasurer of AMCHP, and is the Past-President of AMCHP. She serves on the Florida Developmental Disabilities Council.

/2013/ Phyllis Sloyer is no longer with the Department of Health. //2013//

Mary Beth Vickers, R.N., M.S.N., joined Children's Medical Services as Bureau Chief for CMS Network Operations in June 2010. She has been serving as Acting Division Director for CMS since November 2011. Previously, Ms. Vickers was the Executive Director of a home health agency, served as an instructor in nursing at Florida State University and Tallahassee Community College, and owned and operated a case management company. During her tenure with the Department of Health, she has worked as a nursing consultant with the Florida Board of Nursing and served in a variety of CMSN programs in the nursing consultant role, as well as the Director of the Qualify and Practice Management Unit.

/2014/ Ms. Vickers has been formally named as the Division Director of Children's Medical Services. //2014//

/2015/ Ms. Vickers is no longer with CMS, and currently serves as the department's Deputy Chief of Staff. //2015//

Peggy Scheuermann, M.Ed., C.P.M., the Bureau Chief for the CMS Bureau of Child Protection and Special Technology and has been with CMS since 1998. Prior to working for the Department of Health, Ms. Scheuermann worked for a variety of social services agencies in the areas of criminal justice, domestic violence, and child welfare. She currently serves on several statewide advisory councils on substance abuse prevention and child welfare.

Charlotte Curtis, R.N., B.S.N., C.P.M., has served as the Executive Community Health Nursing Director with the CMS Network since 2006, currently serving as the Director of Program Planning and Development. She has been serving as Acting Bureau Chief for CMS Network Operations since November 2011. Prior to joining CMS in January 2006, for the Partners in Care: Together for Kids Program/CHIPACC, she served as a Nursing Consultant for the Maternal and Child Health Unit and Executive Community Health Nursing Director for the Child and Adolescent Health Unit. She has been the Department of Health since 1998. Ms. Curtis has been instrumental in the development, implementation and expansion of the first publicly funded palliative care program in the nation, and provides technical assistance to other states who would like to replicate Florida's palliative care model.

/2014/ Ms. Curtis was appointed as Bureau Chief for CMS Network Operations and Title V CSHCN Director in November 2012. Ms. Curtis was also appointed to the Florida Developmental Disabilities Council in 2013. //2014//

/2015/ Ms. Curtis was appointed as Interim Director, CMS Programs in January 2014. //2015//

Susan Redmon, R.N., M.P.H., C.C.M., joined CMSN in 1997. She currently serves as the Program Director for the CMS Partners In Care: Together For Kids palliative care program, the statewide health care transition liaison, and the programmatic telemedicine liaison. She serves on the Board of Directors of the Florida Alliance for Assistive Services and Technology, the Florida Developmental Disabilities Council, and is the Chair of the Health Care Task Force, Florida Developmental Disabilities Council.

/2014/ Ms. Redmon is no longer with Children's Medical Services. //2014//.

E. State Agency Coordination

The Department of Health provides or coordinates public health services through headquarters programs, local health departments, CMS area offices, primary care associations, and tertiary care facilities. Services are often provided in collaboration with other state agencies, including:

education; juvenile justice; corrections; social services; child welfare; Medicaid and SCHIP; social security; emergency medical services; and alcohol, drug abuse, and mental health. This effort focuses on health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the population.

In order to present an integrated, seamless service delivery system to families of vulnerable children, the Division of Family Health Services works in close collaboration with Children's Medical Services to ensure communities have procedures for coordinating services to those eligible for both Healthy Start and the CMS Early Steps Program.

School health services are provided under the direction of the Department of Health and in cooperation with the Florida Department of Education. Comprehensive school health service projects provide health care services in schools with high incidences of underserved high-risk children, teenage pregnancy, and poor birth outcomes.

Under Title XXI and Medicaid, the MCH role in the State Children's Health Insurance Program is to ensure access to care through outreach and the eligibility application process, provide interagency coordination, and staff the KidCare Coordinating Council. CSHCN are served through the CMS Network. The Florida KidCare plan provides services to children under 200 percent of the federal poverty level from birth to age 19 through either a Medicaid managed care plan, MediPass, or through the Title XXI programs, MediKids and Florida Healthy Kids. MediKids is for children age 1 to 5.

The Department of Health works in partnership with the Department of Children and Families (DCF) and the Ounce of Prevention Fund of Florida on implementation of the Healthy Families Florida initiative. Healthy Families Florida provides a community-based approach that uses intensive home visiting and coordination with other support services to build an integrated, coordinated, and comprehensive system of support for the prevention of child abuse and neglect. The agencies work together to avoid duplication of services and to facilitate services needed by families served in either program.

/2012/ The Department of Health partnered with the Department of Children and Families to establish the Maternal, Infant and Early Childhood Home Visiting Program. A federal grant by the Health and Human Services will provide $31.5 million over a five-year period to implement the program. The objective to provide services to families at high risk of experiencing domestic violence, unemployment, substance abuse, poor birth outcomes, and low educational achievement. At this time, the department does not have budget authority to continue the grant program. //2012//

In addition, the Department of Health has a letter of agreement with the Department of Children and Families that details collaboration between the two agencies to facilitate services for clients of both agencies. The letter of agreement includes interagency collaboration relating to facilitating the following health care services to DCF clients and its contracted service providers: HIV counseling, testing, and AIDS clinic services; family planning; Healthy Start; Early Intervention Program (Infants and Toddlers) services; prenatal care; immunizations; primary care/EPSDT; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); dental care; multiple handicap assistance teams; medical foster care; and other services as appropriate.

Coordination with WIC includes collaboration regarding breastfeeding initiatives, early entry into prenatal care, coordination with Healthy Start, addressing nutrition issues such as folic acid to prevent neural tube defects, and the development of general nutrition guidelines for inclusion in the Healthy Start standards. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's Federal Healthy Start projects in selected counties, and other MCH-funded projects, including the Pediatric Pulmonary Project at the University of Florida, the MCH program of the College of Public Health at the University of South

Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the Florida State University Center for Prevention and Early Intervention, and Community Integrated Services Systems (CISS) grants related to reproductive health and child abuse and neglect prevention.

Coordination with the Family Planning Program, which includes work on reducing teen pregnancy, reducing subsequent births to teens, preconception and interconception education and counseling, and abstinence education, has long been an integral part of our MCH efforts. This relationship was further enhanced in 2003 when the Family Planning Program (formerly housed within Women's Health) merged with the Maternal and Child Health Unit, to form the Infant, Maternal, and Reproductive Health Section. This reorganization reflects a desire to fully integrate women's health care through the preconception, prenatal, and interconception periods, in order to promote optimal health prior to and between pregnancies, to help ensure positive birth outcomes.

The Department of Health and the Department of Children and Families continue coordinated efforts to prevent substance abuse during pregnancy and to reduce the impact of children affected. The department works to increase the proficiency of health care providers in recognizing and getting needed treatment for women who abuse drugs during pregnancy and for substance-exposed infants, and in identifying and working toward resolution on issues impacting continuous and comprehensive prenatal and infant care for this high-risk population. One concrete example of these collaborations is Fetal Alcohol Spectrum Disorders -- Florida Resource Guide, which has been included on CSAP's FASD Center for Excellence website as a recommended resource.

In an effort to ensure that we continue to employ best practices to help reduce infant mortality, the Department of Health and the Florida Association of Healthy Start Coalitions have assembled a statewide Research to Practice Workgroup. The purpose of the workgroup is to review existing and ongoing research to ensure the continued effectiveness of the Healthy Start model. The workgroup will employ evidence-based practices to evaluate the Healthy Start program at the state and local levels, providing program improvements through the identification, implementation, and evaluation of best practices across the state.

The department works collaboratively with Florida universities to implement maternal and child health initiatives. These collaborations enable the state to access resources unique to the university setting. The Perinatal Data/Research Center, located at the University of Florida, provides a warehouse for maternal and child health data. The center stores and validates data, links related data files, publishes and analyzes data, and studies the impact of program interventions on health status outcomes. The department also serves as a site for public health, nursing, and social work interns from Florida A&M University and Florida State University.

Community health centers play an important role in Florida's health care delivery system. There are 41 community health centers in Florida and 283 clinic locations, though not every clinic provides a full-range of services. Centers are located in 54 of the 67 counties in Florida. Funded in part by the U.S. Public Health Service, they provide care in federally designated medically underserved areas. The centers offer primary health care, preventive health services, emergency medical services, transportation services, preventive dental care, and pharmaceutical services. Their patients include high-risk clients such as migrant farm workers, low birth weight infants, the elderly, homeless people, and HIV patients. A number of Healthy Start coalitions contract with the centers for prenatal care and infant services, based on need and available resources. In some areas, the centers play an active role as members of the local Healthy Start coalition, which might include activities such as service delivery planning.

The Bureau of Chronic Disease Prevention implements and manages the department's chronic disease prevention and health promotion efforts. The prevention and control of chronic diseases reduce premature death and disability and optimize individual and community health in Florida. Bureau programs address the leading causes of death in Florida (heart disease, cancer, stroke, and diabetes), the national leading health indicators (overweight and obesity, physical inactivity

and poor nutrition, and tobacco use), and risk factors for chronic disease, asthma and epilepsy, which are all disabling conditions that affect quality of life.

The bureau develops policies and procedures, analyzes legislation and provides information to the Florida Legislature, develops and monitors contracts and local health department service delivery, and writes and manages grants; Bureau staff collects, analyzes, and disseminates data; conducts statewide and local media and radio campaigns promotes national guidelines for chronic disease prevention, identification, and treatment. These efforts promote evidenced-based community and clinical preventive services, promote healthy lifestyles through health education, and assist in the organization of statewide partnerships to develop and implement strategic plans to prevent and control chronic diseases and conditions.

Local DOH health departments provide chronic disease prevention services directly to individuals and groups. The local health departments partner with community organizations, support and implement chronic disease prevention and health promotion activities, promote health education, and provide risk assessment and screening services. These services include, but are not limited to, cardiovascular disease, diabetes, and cancer education classes; nutrition assessment; smoking cessation assessment and counseling; physical activity assessment and counseling; community health promotion and disease prevention presentations; and screening for hypertension, blood lipid, diabetes, and breast, cervical and colorectal cancers. The local health departments also implement the epilepsy medication and insulin programs.

Projects that specifically relate to maternal and child health include:

Community Gardens: Each spring the Comprehensive Cancer Control Program implements the "Grow Healthy" Garden project, which has been providing an increasing number of school garden kits and materials to the Department of Education for their program of "Gardening for Grades" as part of the Florida Next Generation Sunshine State Standards (http://www.fldoe.org/bii/cshp/schoolgar.asp). Additionally the program provides over 50 community garden kits statewide through a simple application process.

Road to Health Curriculum: The Road to Health Toolkit (RTH) provides community health workers with interactive tools that can be used to counsel and motivate those at high risk for type 2 diabetes. These tools will help reduce their risk for type 2 diabetes by encouraging healthy eating, increased physical activity, and moderate weight loss for those who are overweight. Women who have gestational diabetes (GDM) have a 20-50 percent chance of developing diabetes within 5-10 years postpartum. The Diabetes Prevention and Control Program has partnered with Florida's Healthy Start Coalitions to identify and educate women at risk for type 2 diabetes due to previous or current history of GDM.

The Communities Putting Prevention to Work Program (CPPW) consists of two components. Component I focuses on obesity prevention and tobacco cessation/prevention through local policy and environmental change promoted by 13 regional coordinators located throughout the state. These activities include increasing physical activity for elementary aged children through participation in the Safe Routes to School -- Walking School Bus Program, increasing support for lactating employees of state agencies and school districts, and increasing the number of tobacco-free parks and recreational facilities. Component II of CPPW provides resources to implement an evidence-based, comprehensive physical activity program in all 590+ Florida middle schools. Training will be delivered to designated teachers and Train the Trainer training will be conducted in the summer of year two to certify future trainers in an effort to assure sustainability of this program.

The programs mentioned above demonstrate the bureau's belief in promoting health across the lifespan. The decline in the amount of physical activity that children engage in begins in middle school; however, students who are physically active in middle school have a greater likelihood of becoming physically active adults. Adults who are physically active significantly reduce their risk

of heart disease, stroke, and other chronic diseases such as diabetes. It is expected that this future generation of healthier adults will result in reduced future healthcare costs. The bureau will continue to collaborate with the Infant, Maternal, and Reproductive Health Section sharing data, initiatives, and interventions that affect all residents in Florida.

/2013/ The Bureau of Chronic Disease Prevention and the Infant, Maternal and Reproductive Health Section was one of 10 sites chosen by the Association of Maternal and Child Health Programs (AMCHP), the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) to establish a collaborative project to focus on: 1) recognizing the rising prevalence of GDM; 2) screening more women identified with GDM postpartum for continued elevated blood glucose; and 3) the importance of treating those women identified with subsequent type 2 diabetes. Making systemic changes to the way we provide health care services to these women could substantially reduce these costly adverse health outcomes. //2013//

/2014/ The Florida GDM Collaborative has engaged stakeholders to advance the goals identified. The collaborative developed and distributed copies of the "Gestational Diabetes in Florida, 2013", report, and a Fact Sheet on Gestational Diabetes. The information was shared with Florida's Pregnancy-Associated Mortality Review team and ACOG representatives. //2014//

Florida utilizes funding from HRSA through the State Systems Development Initiative Grant Program (SSDI) to enhance and improve statewide data capacity. Efforts have included: establishing and improving linkages between existing data files; developing and expanding local level data access and capacity; expanding the agency's data capacity for national reporting; and increasing the evaluation and analytic activities for MCH issues. Immediate goals include: improve access to linked and unlinked files for the department, for state partners and for Florida communities while protecting confidentiality and program integrity; improve accuracy, efficiency and sustainability of current file linkage activities; and improve use of linked and unlinked files for policy and program purposes. The ultimate goal of the SSDI grant is to have information needed to improve the health of women, children and families in a useable format that is readily available to people who can make decisions at individual, family, neighborhood, community, or state levels.

/2013/ The Florida Department of Health has been awarded continuing SSDI grant funds for a two-year grant cycle that runs from February 2012 through November 2014. For this grant cycle, the Florida Department of Health will develop analytic plans to measure, track, and assess Title V priority areas and the overarching Title V block grant themes. The Florida SSDI project will publish and/or disseminate data documents as determined by analytic plans. Two annual evaluations will be conducted to assess performance of grant activities and objectives; assess data products generated from SSDI grant efforts; measure the satisfaction of MCH stakeholders with SSDI output and products; and collect input on future MCH data needs and data processes. //2013//

/2014/ The Florida Department of Health has been awarded continuing SSDI funds for a two-year grant cycle that runs from February 2012 through November 2013. For this grant cycle, the Florida Department of Health is now implementing analytic plans to measure, track, and assess Title V priority areas and the overarching Title V block grant themes. Reductions in the 2012 and 2013 grant year funds have limited the ability to conduct the planned evaluations. Application for a new grant cycle was slated to begin in July 2013, but MCHB has stated that the two-year grant period is likely to be extended an additional year ending in November 2014. Despite these funding limitations, the Florida SSDI project continued to publish and present data on Title V priorities, such as contraceptive use, Sudden Unexpected Infant Deaths and safe sleep practices, pregnancy-associated mortality, and breastfeeding practices. //2014//

/2013/ Florida is collaborating with other states in HRSA Region IV as part of March of Dimes, Every Woman Southeast Initiative. This multi-state partnership is designed to share and develop expertise on preconception and interconception health care, policies, research, programs, social

marketing, and evaluation in order to improve the health of women and infants. Each of the states included in Region IV, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee, have high rates of infant mortality and morbidity, chronic disease, sexually transmitted infections, obesity, unplanned pregnancy, and poverty. Minorities in these areas are affected at even greater rates. This collaborative effort, with a focus on a woman's health before, during and after pregnancy, is expected to have a positive impact on women's health, infant mortality and other pregnancy outcomes. //2013//

/2013/ The Department's Infant, Maternal, and Reproductive Health Section (IMRH) is contracting with the University of South Florida's Lawton & Rhea Chiles Center for Healthy Mothers and Babies to support the efforts of the Florida Perinatal Quality Collaborative (FPQC). The purpose of the FPQC is to improve maternal and infant health outcomes through the delivery of data-driven, value-added, and cost-effective MCH services. The FPQC engages perinatal health care stakeholders in the design, implementation, and evaluation of processes and quality improvement efforts. The partnership with the FPQC is expected to lead to improved maternal and infant care, quality, and safety, and a decrease in non-medically indicated deliveries less than 39 weeks gestational age. //2013//

/2014/ The Department's Infant, Maternal, and Reproductive Health Section (IMRH) is continuing to contract with the University of South Florida's Lawton & Rhea Chiles Center for Healthy Mothers and Babies to support the efforts of the Florida Perinatal Quality Collaborative (FPQC). The (FPQC) has expanded the quality improvement project to decrease non-medically indicated deliveries <39 weeks beyond the six pilot hospitals to 47 maternity hospitals with maternity services and has expanded outreach via grand rounds, webinars, conference calls, e-bulletins and presentations. A bi-annual meeting of stakeholders and perinatal professionals has been instituted. The FPQC is now in the development phase for a quality improvement project for the Management of Obstetric Hemorrhage. An advisory team was assembled with expertise in obstetrics, maternal/fetal medicine, nurse midwifery, and maternity nursing in partnership with American College of Obstetricians and Gynecologists (ACOG) District XII to develop the proposal. The contract includes a Statement of Work that calls for implementation of the Management of Obstetric Hemorrhage strategies within selected pilot hospitals. //2014//

/2014/ The IMRH Section, Family Planning Program, collaborated with the Bureau of Communicable Disease, HIV/AIDS Program to provide educational materials in support of statewide efforts that focus on at-risk populations. Contraceptive kits were purchased and distributed to Targeted Outreach to Women with AIDS (TOPWA) program outreach workers. The kits contain samples and fact sheets for the most popular and effective contraceptive methods, and are used for educational and demonstrative purposes. Samples of safe sex materials and safe sex educational pamphlets were also included. The kits were assembled into zippered three-ring binders with handles for ease of transport and accessibility in community settings. An additional 155 kits were purchased and distributed to local health department family planning programs for reproductive health counseling and education in clinic and community locations. Title V block grant funds were utilized to support these efforts. //2014//

/2014/ In May 2012, the Association of Maternal and Child Health Programs (AMCHP) opened an opportunity for states to participate in a national project funded by the Kellogg Foundation called the Life Course Metrics Project. The project's goal is to develop standard life course indicators that will provide the means to improve monitoring and assessments of health for Florida's MCH population and the impact of programs implemented. The Division of Community Health Promotion convened a state team and applied to participate. In June 2012, the department received notification of acceptance into this year-long project along with six other states. Shortly after award notification, Ghasi Phillips, CDC MCH Epidemiology assignee, assumed primary leadership and coordination role for the Florida team with Kris-Tena Albers, Florida's Title V Director, serving as co-lead. The Florida team was assigned 16 indicators to research and write-up as structured assessments. The research/assessments were written by volunteer public health and demography students, division staff and two Healthy Start Coalition partners. The

write-ups will be forwarded to the national project leads to assess with other states' submittals. The 16 measures researched by the Florida team included: adolescent depression, adolescent smoking, asthma, chlamydia, diabetes, gestational diabetes, HIV, hypertension, infant mortality, low birth weight, postpartum depression, pregnancy induced hypertension, pregnancy related death, preterm birth, repeat teen birth, and teen birth. //2014//

/2014/ From 1995-2009, Florida had a substantial increase in hospital inpatient discharges of newborns diagnosed with Neonatal Abstinence Syndrome, increasing from 0.4 to 4.4 discharges per 1000 live births. Within the last six years, the number of hospital inpatient discharges of newborns diagnosed with NAS in Florida has reportedly increased five-fold. To address this problem, Florida's Attorney General established the Prescription Drug Abuse and Newborn Task Force to determine the full extent of NAS in Florida and provide lawmakers with recommendations on how to address the problem. A key finding from the task force is women avoid prenatal care fearing the involvement of child welfare agencies. An objective is to assess evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child. The department has requested technical assistance from the CDC in the form of an EPI-Aid to address this issue. The main objectives of this investigation are twofold. First, this Epi-Aid will assess the validity of Florida's Hospital Inpatient Discharge Data as means of NAS passive surveillance. Findings are expected to help identify case ascertainment methodologies that warrant improvement. Second, the investigation will assess breastfeeding practices as they relate to NAS scores over time, length of hospital stay, and other characteristics of infants with NAS. This assessment addresses one objective of the Florida Prescription Drug Abuse and Newborn Task Force, "Assess evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child." Furthermore, epidemiologic studies have shown that infant feeding practices is one of the major components in the management of NAS and that breastfeeding may result in better NAS outcomes. Findings of this Epi-Aid objective are expected to support efforts to treat and manage NAS in Florida. //2014//

/2014/ The department is participating in the Collaborative Improvement & Innovation Network (COIIN). The COIN is a partnership with the Association of Maternal and Child Health Programs (AMCHP), the Association of State and Territorial Health Officials (ASTHO), CityMatCH, the March of Dimes, and Federal partners including the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) and 13 southern states to develop plans and intensify efforts to prevent premature births and improve birth outcomes to reduce infant mortality.

The COIIN is focusing on five common priority strategies to facilitate collaborative learning and adoption of proven quality improvement principles and practices. The five key strategies are: 1) eliminating elective deliveries prior to 39 weeks gestation, 2) prenatal smoking cessation, 3) safe sleep for infants, 4) Medicaid financed interconception care for women with a prior adverse pregnancy outcome and 5) strengthened regional perinatal care systems.

Through the COIIN, state agencies across the 13 southern states are designing modern, effective approaches for change. Together these states are focusing on ways to ensure health equity, eliminate health disparities, and implement best programs, policies, and practices to reduce infant mortality. //2014//

/2014/ In 2011, the Statewide Family Planning Program initiated the strategies to achieve this mission by implementing goals and objectives to increase awareness of and access to quality FP services throughout the state. The 2011 Title X Needs Assessment process was used to help identify program priorities and various initiatives. As a result of the needs assessment process, current state initiatives include: increasing funding for the purchase of additional long acting contraceptives (LARCs), and continued education and promotion of limited English proficiency in counties, and the collaboration of FP and STD/HIV AIDS prevention programs to offer screening, treatment, and referral services. //2014//

/2014/ During 2011-2012 and 2012-13, to promote optimal wellbeing for mothers and babies, especially as it relates to improving birth outcomes and preventing early childhood caries, the IMRH Section allocated $1,079,295 and $979,448, respectively, in MCHBG funding to the local health departments to use for providing dental services to women and children, In 2012-2013, the IMRH Section also collaborated with the DOH Public Health Dental Program by allocating $600,000 to specifically serve uninsured and underinsured pregnant and postpartum women up to six months. //2014//

/2015/ The Department of Health's Maternal and Child Health Section has provided funding to and collaborated with the Florida Perinatal Quality Collaborative (FPQC) to support the development of the Obstetric Hemorrhage Initiative, to address one of the top causes of maternal death identified by Florida's Pregnancy Associated Mortality Review (PAMR). The initiative is currently engaging 31 Florida hospitals in comprehensive approaches to address and reduce the incidence of postpartum hemorrhage. The department also supports FPQC efforts to improve pregnancy outcomes for women by providing data support through its Bureau of Vital Statistics and through collaboration with the FPQC on activities of the Collaborative Improvement and Innovation Network (CoIIN). //2015/

/2015/ The American Congress of Obstetricians and Gynecologists (ACOG) District XII collaborates closely with the department and fills leadership roles for Florida's PAMR project. This close association has enhanced communication with obstetric providers in Florida, as demonstrated through statewide messaging of the ACOG membership regarding an increase in the number of pregnant women with severe complications from H1N1 flu during the 2013-2014 flu season. Provider alerts, information for treatment, and information on the activation of Medicaid reimbursement codes for flu vaccine were disseminated in partnership with the department. //2015//

/2015/ The Maternal and Child Health Section collaborated with the Bureaus of Tobacco Free Florida and Chronic Disease Prevention, March of Dimes, and the Florida Association of Healthy Start Coalitions (FAHSC) to implement statewide, the evidence based Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program as part of the Healthy Start redesign. This collaboration resulted in a joint effort to purchase program materials and provide staff training. To build additional capacity and sustainability in the state, FAHSC and the department will designate staff to become Master Trainers in SCRIPT, which will enable the department to organize train-the-trainer workshops in the future. The SCRIPT Master Trainers will be trained to conduct workshops and offer technical assistance to programs implementing SCRIPT. In addition, FAHSC will work with the SCRIPT developers to create a Florida-specific Training and Implementation Guide to ensure program quality and effectiveness. The guide will integrate requirements of the Healthy Start Standards and Guidelines (HSSG) for delivery of smoking cessation services. //2015//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	35.6	37.7	40.1	35.1	24.4
Numerator	4046	4281	4254	3782	2649
Denominator	1136803	1136370	1060331	1077930	1084436

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Population data (denominators) for 2012 and 2013 come from the Florida Office of Economic and Demographic Research (posted on Florida Community Health Assessment Resource Tool (CHARTS). Data on hospitalizations of children less than 5 years of age (numerators) comes from Florida Agency for Health Care Administration.

Narrative:
There were a number of efforts in FY2011 to reduce early childhood asthma. The Healthy Start program assessed the homes of pregnant and parenting mothers on indoor air quality issues. The Maternal and Child Health Section worked to reduce the prenatal smoking rate through education on the relationship between secondhand smoke sudden infant death syndrome, lung problems, ear infections, and more severe asthma.

The Division of Environmental Health inspected daycare and pre-kindergarten facilities. The Asthma Prevention and Control Program led efforts to improve asthma outcomes and reduce disparities; conduct asthma surveillance and evaluation; and increase the number of childcare centers, schools, and hospitals with asthma management programs.

/2014/ The Bureau of Family Health Services has been updating its Nursing Guidelines for the Delegation of Care for Students with Asthma in Florida schools. The School Health Program monitors local school health programs for individualized healthcare planning for students with asthma. //2014//

/2014/ The Healthy Start Program and the MCH Section addressed childhood asthma through efforts to reduce tobacco use and educate pregnant and parenting mothers on issues related to household indoor air quality, such as use of tobacco products, dust, animal dander, and other allergens. //2014//

/2014/ The Florida Asthma Program led efforts to improve asthma outcomes and reduce disparities. The program works with the Florida Asthma Coalition, to address childhood asthma through the Asthma-Friendly Child Care Center and Asthma Friendly School Initiative by recognizing them for participating in asthma training and activities such as posting asthma awareness posters, using asthma action plans, and controlling asthma triggers.

/2015/ During FY2014, the Bureau of Family Health Services and Department of Education worked with public and private professionals to update the Guidelines for the Care and Delegation of Care for Students with Asthma in Florida Schools: School nurses continued to work with students, parents, and physicians to promote improved asthma management. //2015//

/2015/ The Florida Asthma Program coordinated statewide efforts to improve asthma outcomes and reduce disparities. The program works with the Florida Asthma Coalition, to address childhood asthma with the Asthma-Friendly Child Care Center and Asthma Friendly School Initiative by recognizing them for participating in free asthma training and completing other activities such as posting asthma awareness posters, keeping asthma action plans on file, and controlling asthma triggers. The Florida Asthma Program will

compete for another five-year round of funding that starts in FY2015. //2015//

/2015/ The Environmental Health Program performed environmental health inspections (including indoor air quality) at daycare facilities and pre-kindergarten, primary, and secondary schools. //2015//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	100.0	76.4	77.7	77.7	78.9
Numerator	138961	108268	110663	110663	113585
Denominator	138961	141645	142389	142398	144049
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data for 2013 comes from AHCA for Federal Fiscal Year 2012/2013.

Notes - 2012
Data for 2012 comes from AHCA for Federal Fiscal Year 2011/2012.

Narrative:
Local organizations and communities initiate outreach activities to increase awareness of the availability of Medicaid coverage for eligible children, and the Florida KidCare partners ensure the public understands families may apply for and have their eligible children enrolled in Medicaid at any time. In addition, the Covering Kids Coalition is working to ensure that eligible low-income children apply for Medicaid coverage through Florida KidCare through collaboration with community, regional, and state organizations and Florida KidCare community coalitions.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	44.3	60.5	61.5	62.2	60.2
Numerator	402	1097	1172	1198	1104
Denominator	907	1812	1905	1925	1835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data from AHCA, Fiscal Year 2012/2013.

Narrative:
In Florida, infants up to age 1 year whose family income is at or below 200 percent of the Federal Poverty Level (FPL) are income eligible for Medicaid. For families with family income at or below 185 percent of FPL, the infant's coverage is financed by Title XIX of the Social Security Act. For families with incomes from 186 percent through 200 percent of the FPL, the infant's coverage is financed by Title XXI of the Social Security Act (CHIP), but the child is enrolled in Medicaid. The Agency for Health Care Administration collects data on the number of CHIP enrollees who receive at least one initial or periodic screen and shares that with the Department of Health.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	71.2	71.3	72.0	71.0	70.0
Numerator	138142	131093	137448	140627	138698
Denominator	193896	183900	190786	197966	198047
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The department works in collaboration with Healthy Start coalitions statewide to ensure an adequate infrastructure is in place for the provision of first trimester prenatal care and continuous care for all pregnant women. The MomCare program, implemented statewide during FY2002, facilitates Medicaid coverage for prenatal care under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare provides prenatal care choice counseling outreach, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive health related enabling services. MomCare sends a seven-month packet to all clients that includes information on the Family Planning Waiver. MomCare provides follow-up services as needed to recipients as well as a mandatory post-enrollment follow-up service to all recipients between the sixth and ninth month of facilitating access to family planning services, health care coverage for the infant and help choosing a pediatrician for the infant. Follow-up can be by telephone or by mail. We continued to ensure the statewide process of presumptive and Simplified Medicaid eligibility for pregnant women. Additionally, we work through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.

/2014/ Currently, the department implements and monitors the MomCare program, as a part of the Healthy Start Program, in collaboration with Florida's Medicaid agency, the Agency for Health Care Administration (AHCA), and the Healthy Start Coalitions. As a result of action taken during Florida's 2011 legislative session, the implementation of the 1915b Waiver and SOBRA (MomCare) will be moved from the department to AHCA's purview beginning October 1, 2014.

The department is working closely with AHCA and coalition staff in an effort to assure a seamless transition. //2014//

/2015/ Beginning July 1, 2014 the 1915b Waiver and SOBRA (MomCare) will move from the department to AHCA. Additional information on the impact of this move can be found in the state overview section as a /2015/ update near the end of the state overview section. //2015//

/2015/ In order to comply with the Affordable Care Act, Florida has revised the application process for Florida Medicaid through a web portal called ACCESS Florida. Pregnant women can apply for PEPW on the integrated on-line public assistance computer system that is used to determine eligibility for PEPW as well as other public assistance programs, such as Food Assistance, Medicaid, and Temporary Cash Assistance. //2015//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	71.4	70.5	71.9	73.7	91.4
Numerator	1606835	1676229	1673213	1736576	2207299
Denominator	2250889	2376663	2328090	2356719	2413860
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Increase in FY 2013 is due to a change in methodology to include Medicaid HMO capitation payments for children.

Narrative:
The Florida KidCare partners continue to work with community-based organizations, healthcare providers, and others to ensure people understand the Medicaid program availability. The Covering Kids and Families project at the University of South Florida implemented special initiatives to work with hard-to-serve populations and leaders in minority communities to ensure that they promote the Florida KidCare message to eligible children year-round. These services are targeted towards providing easy-to-understand, accurate information about children's health insurance and preventing loss of coverage among eligible children in the state.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	29.7	29.4	31.1	36.3	41.0

Numerator	131003	145003	132829	165043	197257
Denominator	441239	493660	427525	454317	481109
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Based on 2013 EPSDT Report from the Florida Medicaid Program.

Notes - 2012
Based on 2012 EPSDT Report from the Florida Medicaid Program.

Notes - 2011
Based on 2011 EPSDT Report from the Florida Medicaid Program.

Narrative:
Improving access to dental care for low-income persons below 200 percent of the federal poverty level is a priority of the department. Over the last several years, the department has funded initiatives to expand the infrastructure of local health department safety net dental programs. During 2011, three additional counties began to provide dental services, increasing the total number of Florida counties with dental programs to 53. A large majority of clients served through county programs are Medicaid-enrolled children, and during 2011 the number of Medicaid children receiving dental care through the local health departments grew from 112,848 in 2010 to 136,293, a 20.7 percent increase. A state oral health improvement plan for disadvantaged persons utilizes ongoing broad-based stakeholder input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. The state oral health coalition, Oral Health Florida, and numerous local coalitions work collaboratively to implement diverse strategies around prevention, education, and treatment.

/2014/ Improving access to dental care for low-income persons below 200 percent of the federal poverty level continues to be a priority of the department. The department continued to fund initiatives to expand the capabilities of local health department safety net programs. Last year two additional counties were provided funds to establish dental programs. Florida continues to work with the Oral Health Florida coalition to facilitate coordination between the public and private sectors. Oral Health Florida utilizes ongoing broad-based stakeholder input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. Several local coalitions continue to educate their local communities on the diverse strategies which include preventive, educational, and treatment measures. //2014//

/2015/ The DOH continues to focus on oral health initiatives addressing disparities of low income persons below 200 percent of the federal poverty level and increasing dental services provided through safety net providers. Dental services provided by local health departments and other local safety net providers have increased steadily since 2009, resulting in 10 percent more children being served during the last five years. Expansion of services include oral health screenings; dental sealants, and restorative services delivered by dental providers; and preventive services such as screenings, fluoride treatments, and referrals by pediatricians, medical providers, and nurses in medical offices and school-based/school-linked health settings. Local coalitions, public and private organizations, and schools collaborate to provide an integrated system of care, prioritizing oral health as a major component of comprehensive health services. //2015//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	16.5	20.8	17.1	21.7	24.8
Numerator	12506	16566	14447	23377	27552
Denominator	75723	79708	84352	107700	111008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
When a family, who meets the financial eligibility criteria for SSI, applies for benefits, the application is sent to the Office of Disability Determination Services for a medical eligibility decision. After a medical decision is made, the information about the child, whether eligible or not eligible for SSI benefits, is sent to the CMS Program Office. The CMS SSA/SSI Liaison reviews the information about the child. The information about the child is sent to the CMS office in the area where the child resides. An individual in the local CMS office contacts the child's family to find out if the child has a health care provider. If not, the family is invited to apply for services of CMS. When a child with mental illness applies for SSI benefits, the CMS SSA/SSI liaison sends the information about that child to the Children's Mental Health Program in the Department of Children and Families for follow-up.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2012	matching data files	9.4	7.1	8.5

Narrative:
As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Infant deaths per 1,000 live births	2011	matching data files	7.9	4.3	6.4

Narrative:
As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2012	matching data files	74	90.1	80.3

Notes - 2015
Percent of infants born to women who began care in the first trimester differs from the values provided on Form 11 NPM #18 because births with unknown linking information are excluded.

Narrative:
As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2012	matching data files	61.8	73.7	66.3

Notes - 2015

Data for "all" column differ from numbers reported elsewhere in report, as this data comes from a different source. Source for this data looks at matched data files that exclude those without an SSN number. In the case of multiple births, multiple births are counted as one delivery, further skewing the results. Data for this indicator is more accurately reflected on Form 17.

Narrative:
As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	200

Narrative:
Infants 0 to 1 whose family income is 185 percent of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Infants 0 to 1 whose family income is between186 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Medicaid.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2013	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2013	 200 200

Narrative:
Children ages 1 to 6 whose family income is 133 percent of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Children ages 1 to 6 whose family income is between 134 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Florida KidCare (CHIP). Children ages 6 to 19 whose family income is 100 percent

of the Federal Poverty Level or below are income eligible for Title XIX-financed Medicaid. Children ages 6 to 19 whose family income is between 101 percent and 200 percent of the Federal Poverty Level are income eligible for Title XXI-financed Florida KidCare (CHIP).

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2013	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2013	

Notes - 2015
In Florida, pregnant women are not eligible for SCHIP coverage.

Narrative:
Pregnant women whose family income is 185 percent of the Federal Poverty Level or below are income eligible for Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes

Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

Narrative:
The linkage of Infant Death Certificates includes birth records linked to the following: Fetal and infant death records, Healthy Start prenatal and infant risk screening data, Healthy Start prenatal services, Medicaid and WIC participation, WIC participation, and Census Tract Information

Medicaid Eligibility or Paid Claims Files: Linking maternal Medicaid eligibility files to birth certificates is an ongoing collaboration of the Florida Agency for Health Care Administration; the Department of Health, the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies; and the University of Florida's Maternal Child Health and Education Research and Data Center.

WIC Eligibility Files: The maternal WIC eligibility files are linked to birth certificates as part of the Medicaid collaboration. This linkage provides the data listed under infant death certificates and is included in the annual Medicaid MCH Indicator report.

Newborn Screening Files: When Newborn Screening data was linked to live birth certificates in 2004, it showed that only a small percentage of live births are not receiving newborn screening. Plans are underway to integrate the data entry for live birth certificates and newborn screening at the delivery hospital to establish an ongoing process for identifying newborns not screened.

Hospital Discharge Survey Data: Direct access is limited to de-identified data without a special data sharing agreement. Other parts of the department do have access to identified discharge data.

Birth Defects Registry: SSDI staff continues to work with Birth Defects Registry staff to develop further data linking and utilization strategies. Plans are underway to develop a birth defects research data file that will allow data to be more readily analyzed by internal and external partners including SSDI staff.

/2014/ The department contracts with the Florida Perinatal Quality Collaborative (FPQC) to promote perinatal care quality improvement efforts. One issue of focus is to decrease non-medically indicated deliveries less than 39 weeks gestational age in Florida maternity hospitals with maternity services. The department provides quarterly vital statistics information to FPQC to track and assess trends of non-medically indicated deliveries, statewide and by birth facility. The department provides quarterly vital statistics information to FPQC to track and assess trends of non-medically indicated deliveries, statewide and by birth facility. //2014//

/2014/ Florida's State Surgeon General periodically reviews and updates the Department of Health's list of reportable diseases. Events of public health significance may be added to the list. The substantial rise in the incidence of NAS and the associated public health consequences warrant the addition of NAS to the reportable disease list. Department staff is currently in the process of identifying stakeholders and mapping the process to move this initiative forward. //2014//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Florida Youth Tobacco Survey	3	No

Notes - 2015

Narrative:
There are two surveys in Florida that can be utilized to determine the percent of adolescents who smoke: the Youth Risk Behavior Survey (YRBS) and the Florida Youth Tobacco Survey. We can access the results of the surveys, but the MCH program does not have direct access to the survey databases for analysis.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations. Priorities and state performance measures have been established based on needs assessment activities.

B. State Priorities

State priorities were determined through the five-year needs assessment. That process indicated a need to focus on reducing risk factors that adversely affect outcomes for the maternal and child health population. The priorities also reflect an increased focus on reducing racial disparities. Priorities were determined using both quantitative and qualitative data, as well as the recommendations of our needs assessment advisory committee. Following is a list of the eight state priorities for Florida, and the performance measures they relate to.

1. Prevent unintended and unwanted pregnancies.
SPM#2 The percentage of births with inter pregnancy interval less than 18 months.

2. Promote preconception health screening and education.
SPM#3 The percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy.

3. Promote safe and healthy infant sleep behaviors and environments.
SPM# 4 The percentage of infants not bed sharing.
SPM# 5 The percentage of infants back sleeping.

4. Prevent teen pregnancy.
NPM#8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

5. Improve dental care access, both preventative and treatment, for children.
NPM#9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
SPM#7 The percentage of low-income children under age 21 who access dental care.

6. Increase access to medical homes and primary care for all children, including children with special health care needs.
NPM#3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

7. Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.
NPM#6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.

8. Increase early intervention services for children with special health care needs.
SPM#1 The percentage of Part C eligible children receiving service.

/2015/ The department continues to focus on reducing the disparity between black and white infant mortality as an overarching priority, one of the national outcome measures included in Form 12. Reducing infant mortality for all races has been a challenge, particularly for black infants. We include race as a factor on our prenatal infant screens,

adding one point to the overall total for black women to help ensure women with additional risk factors are more likely to receive the care they need to increase the chance of an improved birth outcome. We anticipate that our focus on specific priorities such as reducing unintended pregnancies, promoting preconception and interconception care, promoting safe sleep, and teen pregnancy prevention, will continue to affect infant mortality disparities in a positive way. //2015//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1279	1294	1218	1175	1314
Denominator	1279	1294	1218	1175	1314
Data Source	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program	Florida Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Florida statutes require that every newborn born in the state must be screened before one week of age. Although parents have the option to refuse the newborn screening test, it is estimated that most newborns participate in the screening process. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with cystic fibrosis, endocrine, and hematology/oncology specialty centers. Specialty referral centers arrange for confirmatory testing and treatment for patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities related to treatment and dietary management are also included. Educational materials are distributed to all

birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening plus information about hearing screening.

In 2012, testing identified 1,175 babies with presumptive positive screening results. After confirmatory testing, 377 were found to have one of the 35 disorders. Of the 377 confirmed cases, all of them received timely follow-up and treatment. Final data for 2013 are not yet available.

Direct Health Care Service activities provided by the department include referral of patients with presumptive positive test results to genetic specialty centers, endocrine specialty centers, and hematology/oncology specialty centers. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening. The previous two activities are population-based services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Florida contracts with three genetic specialty centers for referral of patients with abnormal PKU, Galactosemia, Biotinidase and other metabolic disorder test results.	X			
2. Florida contracts with three endocrine specialty centers for referral of patients with abnormal congenital hypothyroidism and congenital adrenal hyperplasia test results.	X			
3. Florida contracts with 10 hematology/oncology specialty centers for referral of patients with abnormal hemoglobinopathy test results.	X			
4. Florida contracts with 12 Cystic Fibrosis Centers for referral of patients with abnormal cystic fibrosis test results.	X			
5. Specialty referral centers arrange confirmatory testing and treatment to for patients identified through the screening program. Genetic counseling, follow-up and nutritional counseling activities (treatment and dietary management) are included.	X			
6. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Notification was sent to all birthing facilities and providers who care for newborns in December 2013 that Critical Congenital Heart Disease (CCHD) was added to the Florida newborn screening panel of disorders. Activities will consist of surveillance and reporting. It is estimated that the data system modifications to collect the pulse oximetry screening results in June 2014 and reports will be available in the summer of 2014. Florida screens for all 31 disorders recommended by the United States Department of Health and Human Services Secretary's Advisory Committee for Heritable Disorders in Newborns and Children. Florida has advanced ELO/ELR (electronic laboratory ordering/electronic laboratory reporting) implementation activities, being one of only a few states pursuing the transfer of data between the hospital and the Newborn Screening Laboratory. (Hearing Screening Program activities are reported in NPM #12.)

c. Plan for the Coming Year
In addition to the reporting of the hearing screening results through the web-based access application, there are plans to develop a component for CCHD. Hospitals and birthing centers can report the oxygen saturation levels on the specimen card or enter the results using the web-based application. Additional information regarding the outcome of a failed pulse oximetry screening test will be collected on a case report that will include the diagnosis and subsequent intervention and treatment.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**213374**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	211240	99.0	20	7	7	100.0
Congenital Hypothyroidism (Classical)	211240	99.0	146	74	74	100.0
Galactosemia (Classical)	211240	99.0	106	4	4	100.0
Sickle Cell Disease	211240	99.0	230	197	197	100.0
Biotinidase Deficiency	211240	99.0	20	3	3	100.0
Congenital Adrenal Hyperplasia	211240	99.0	23	13	13	100.0
Cystic Fibrosis	211240	99.0	454	42	42	100.0
MS/MS disorders	211240	99.0	172	34	34	100.0
Severe Combined Immunodeficiency	52810	24.7	4	3	3	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	54	53	55	69	70
Annual Indicator	50.2	50.2	68.2	68.2	68.2
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	National Survey of Children with Special Health Ca	National Survey of Children with Special Health Ca	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	71	72	73	74	75

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The University of Florida Institute for Child Health Policy continues to conduct satisfaction surveys, under contract, for the CMSN. Populations within CMS are identified for surveys to support internal and other performance improvement measures. Surveys are aimed at describing and quantifying satisfaction and health-related quality of life for children enrolled in the CMSN.

In addition, CMS continues to collect data from each of the 21 area offices for its performance measures. The data is collected through the electronic records that are maintained for each CMS enrollee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family-to-family support and contact will be facilitated throughout CMS.	X			
2. CMS staff will produce and market materials that explain the CMS Mission, Vision, Goals and Services via their website, printed materials, and other forms of media and advertising.			X	
3. Include CMS families in developing policy, training, and in-service education.		X		
4. A statistically significant number of Satisfaction Surveys will be obtained from children, teens, and young adults enrolled in CMS Programs or their families regarding the services received through CMS or a CMS contracted provider.				X
5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2013, CMS continued to partner with the American Academy of Pediatrics and the Florida Agency for Health Care Administration for the Pediatric Medical Home Demonstration Project. CSHCN Director serves on the Expert Panel Group which guides the project. The project is a result of the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant. A total of 16 pediatric primary care practices participate in the project. Core teams have been formed that participate in learning collaborations in 2011 and 2012. Parents serve as one of the four core

team members. CMS sponsors the participation of the parents in the project.

CMS is conducting its annual family satisfaction surveys, as in the past, to continue describing and quantifying satisfaction and health-related quality of life for children enrolled in the CMSN.

c. Plan for the Coming Year
CMS will continue to participate with CHIPRA Pediatric Medical Home Demonstration Project as described above and support parent involvement. CMS will also continue to conduct satisfaction surveys with parents of CMS enrollees.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	47	44	46	38	38
Annual Indicator	41.9	41.9	36.2	36.2	36.2
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile Data for CSHCN Survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	39	40	41	42	43

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used

to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
CMS continued to redefine the patient-centered medical home concept statewide to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based, and culturally competent.

CMS medical home projects focused on recruitment of physicians, specialists, and adult providers to provide services for CMS enrolled clients. Performance improvement reviews of the provider credentialing processes were conducted to improve efficiency and focus on expanding the CMS provider network. CMS recruited area physicians to become CMS credentialed providers and encouraged participation in medical home.

CMS participated in the second phase of a CHIPRA Quality Improvement Project in partnership with Illinois. The Florida Pediatric Medical Home Demonstration Project focused on Core Quality Measures to improve the quality of care, quality of care coordination, implement more comprehensive models of service delivery, and demonstrate the impact of a model electronic health record. CMS is represented on the advisory committee for the CHIPRA project and supported the practices with care coordination staff. CMS participated in a CHIPRA Quality Improvement Project in partnership with Illinois. The Florida CHIPRA Quality Improvement Project did: 1. Test the collection of new CMS core measures and other selected supplemental measures of high priority; 2. Collaborate with ongoing statewide Health Information Exchange (HIE) and Health Information Technology (HIT) development efforts to ensure that child health

quality objectives are integrated, and child health performance measurement and quality improvement are fully supported; 3. Support implementation of enhanced medical homes, through training and technical assistance for practice redesign addressing core medical home measures and creating strong referral and coordination networks, as well as through the integration of HIT; 4. Evaluate the impact of the changes on the quality, coordination and efficiency of children's health care and in particular, children with special health care needs; and 5. Build on measure development and HIT to support collaborative quality improvement projects to improve client outcomes. Florida selected the patient-centered medical home (PCMH) model as its provider-based model. As part of the evaluation process, core team members reported higher ability to adapt to change (adaptive reserve), a key factor to the implementation of PCMH.

CMS continued to implement the phased rollout of an electronic administrative claiming process and comprehensive system of payment accuracy; entered the design phase of the statewide, web-based platform, care coordination documentation system and electronic health record; and conducted an assessment of processes, performance measures, and outcomes.

Addressing recommendations from the Transition Taskforce Report (2009), CMS conducted an assessment of the existing health care transition process to increase access to medical homes for YSHCN with the goal of supporting seamless systems of health care transition for clients transitioning to adult health care services and providers.

CMS continued to expand the Medical Home program into physicians' practices and worked towards providing comprehensive medical home initiatives for all CMS enrolled clients. Physicians continued to partner with CMS in the medical home program and incorporated medical home care coordination, care management, and quality improvement teams in their practices. Medical home practices were offered the opportunity to participate in webinars and receive technical assistance through CMS contracted providers. Technical assistance included practice improvement techniques, ongoing quality improvement initiative (working toward NCQA Medical Home Recognition), medical home care coordination, and ongoing program evaluation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Demonstrate the importance of medical home to the health and well-being of children with special health care needs through statewide data collection, satisfaction surveys, and performance measures.				X
2. Medical home interagency leadership and collaboration through workgroups and participation in the Florida Pediatric Medical Home Demonstration Project.				X
3. National health care transition expertise, model of care, services, resources, training and technical assistance.				X
4. Support initiatives in Telehealth, and other innovative delivery systems, that are built on the CMS medical home.				X
5. Educate physicians and families on the benefits and use of Telehealth.		X		
6. Identify and recruit potential or approved providers to serve CMS children with special health care needs and their families with a focus on recruiting specialists, dental providers, and adult providers.		X		
7. Development and design of third party administrator system. Development and design of electronic documentation care coordination module for statewide implementation in 2014.				X

8. Collaborate with other state agencies and community partners to provide services to children with special healthcare needs, foster children, and Medicaid beneficiaries in a medical home.				X
9. Medical home community outreach opportunities to educate the public in general about medical home at CMS.		X		
10.				

b. Current Activities
CMS continued to implement the phased rollout of an electronic administrative claiming process and comprehensive system of payment accuracy; completed User Acceptance Testing of the statewide, web-based platform, care coordination documentation system and electronic health record; and conducted an assessment of processes, performance measures, and outcomes.

CMS conducted an assessment of care coordination guidelines and policies in preparation for the rollout of the statewide, web-based platform, care coordination documentation system, and electronic health record.

Addressing recommendations from the Transition Taskforce Report (2009), CMS partnered with the Florida Association of Qualified Health Centers to increase access to medical homes for YSHCN with the goal of supporting seamless systems of health care transition for clients transitioning to adult health care services and providers.

CMS focused on recruitment of physicians, specialists, and adult providers to provide services for CMS enrolled clients in PCMH. Performance improvement reviews of the provider credentialing processes were conducted to improve efficiency and focus on expanding the CMS provider network.

CMS reached out to stakeholders in the state and in the Florida Pediatric Medical Home Demonstration Project to assess opportunities to develop and host medical home training opportunities in collaboration with the American Academy of Pediatrics and national and local partners to link them with experts.

c. Plan for the Coming Year
CMS will continue to redefine and improve the patient-centered medical home concept to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based, and culturally competent.

CMS is preparing to become a statewide Florida Managed Care Plan that provides services for the medical assistance Medicaid Managed Care Plan in 2014. Preparations include focusing on Network Adequacy to meet the required Network Adequacy Standards to ensure the Florida Medicaid Medically Complex population will have access to services and care in a medical home.

CMS will continue performance improvement reviews of the provider credentialing processes and evaluate recruitment of physicians, specialists, and adult providers, in order to provide services for CMS enrolled clients, improve efficiency, and focus on expanding the CMS provider network. CMS will continue outreach, education, and recruitment of CMS pediatricians to participate in the statewide medical home plan.

CMS will complete statewide implementation of an electronic administrative claiming process and comprehensive system of payment accuracy; complete rollout of the statewide, web-based platform, care coordination documentation system and electronic health record; and conduct an assessment of processes, performance measures, and outcomes to ensure improved cost effectiveness and efficiency. A new reporting module will be implemented with the new system

that will enhance accountability by improving the quality and quantity of data that CMS can report on.

CMS will complete a total revision of the care coordination guidelines, policies, and procedures that will address the new requirements for operation as a Florida Managed Care Plan. New policies and procedures are being created to address the evolving scope of work CMS is accountable for.

CMS will collaborate with state transition experts to replicate the transition medical home pilot and expand health care transition service delivery for YSHCN. The Transition Taskforce Report, CMS health care transition algorithm, and existing strategic plans provide the framework for the development of a transition medical home process that will be implemented in 2014. CMS is collaborating with transition experts and stakeholders to ensure that YSHCN, between the ages of 12-21, are linked to the appropriate health care transition planning, services, and resources to increase access to medical homes. CMS is participating in Global Telemedicine initiatives to provide access to services for children and youth with special health care needs in other states and countries.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64	60	62	60	67
Annual Indicator	58	58	56.5	64.3	64.3
Numerator				435089	431822
Denominator				676655	671574
Data Source	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey	CSHCN survey and American Community Survey	CSHCN survey and American Community Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance	68	69	70	71	72

Objective					

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
2012 percentage increased in part due to change in methodology using American Community Survey for the population estimate in conjunction with the HRSA national survey of CSHCN.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The U.S. Department of Health and Human Services Health Resources and Services Administration estimates that 14 to 19 percent of children in the United States have a special health care need (2010 HRSA National Survey of Children with Special Health Care Needs -- 2007 Chartbook).

In state fiscal year 2011-12 (July 1, 2011- June 30, 2012), the Children's Medical Services (CMS) Network for children with special health care needs provided health benefits coverage to 69,174 Title XIX-funded and 34,543 Title XXI-funded unduplicated children. In addition, 10,144 unduplicated children qualified for "Safety Net" services, state-funded limited services for children ineligible for Title XIX or Title XXI coverage, or whose private health insurance coverage was insufficient to meet the child's needs.
In state fiscal year 2012-2013, Children's Medical Services (CMS) Network provided full health benefits coverage to 71,258 Title XIX-funded and 33,518 Title XXI-funded unduplicated children. In state fiscal year 2012-2013, and 2,460 unduplicated children qualified for "Safety Net" services.

The Florida KidCare Coordinating Council, created by section 409.818(2)(b), Florida Statutes, includes a diverse membership that makes recommendations to improve the implementation and operation of the Florida KidCare program. Some of the council recommendations from the January 2014 report address fully funding the Florida KidCare program, including annualization needs, projected growth, outreach, and increased medical and dental costs; implementing a medical income disregard for children with catastrophic illness who would otherwise qualify for Title XXI subsidies; implementing the state option Family Opportunity Act; implementing presumptive eligibility for Florida KidCare applicants, and taking advantage of federal funding to cover otherwise eligible legal immigrant children and pregnant women.

Florida KidCare provides families with a variety of written and electronic reminders about premium payments and renewal requirements. In addition to these activities, member services

staff in the Children's Medical Services (CMS) Network communicate with enrollees' families to remind them about premium payments to reduce cancellations for nonpayment. The CMS Network Central Office periodically sends notices to families whose children who have been canceled from Title XXI-funded CMS Network coverage for nonpayment of premium or noncompliance with review to advise them they may contact Florida KidCare to find out how to reactivate coverage if their children are uninsured.

DOH maintains the Florida KidCare website. Staff provides Florida KidCare information to families through CMS, county public health departments, school health, and Healthy Start programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate and coordinate with Medicaid and KidCare offices to strengthen outreach and enrollment strategies.		X		
2. Identify children at risk for and with special health care needs.		X		
3. Utilize quality of care measures for children enrolled in CMS Programs.				X
4. Track health expenditures and costs of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Healthy Kids Corporation supports community outreach campaigns targeting organizations whose memberships and clientele focus on families potentially eligible for FKC. As part of the CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost $1 million to the USF Covering Kids and Families (CKF) Project to help find and enroll eligible children in FKC, and to promote retention, with special emphasis on racial and ethnic minority groups. The Department of Children and Families provides materials and information to their community partners to contact families who do not qualify for Medicaid to encourage them to apply for FKC for their children.

During the 2012 session, the Florida legislature enacted language that allows income eligible children of state employees to enroll in Title XXI-funded FKC. In collaboration with other FCK partners, the DOH continued to reach out to families with potentially eligible children and encourage them to apply for coverage or help eligible children retain their health care coverage.

The FKC partner agencies are implementing required provisions of the Affordable Care Act, going through a transition of the FKC third party administrator (TPA), and completing the TPA transition for the CMS Network for children with special health care needs.

c. Plan for the Coming Year

In early 2013, the Covering Kids and Families project applied for a Connecting Kids to Coverage Cycle III grant from the federal government to increase the number of application assistance center networks throughout the state where families may apply and receive assistance. Partnerships will be in geographic areas of the state with diverse populations and high rates of

uninsured children who may qualify for Florida KidCare. The expansion of one-on-one application/renewal assistance best practices established under the project's Cycle I and Cycle II grants will ensure that families will have help from trusted sources within their own communities, increasing their confidence as well as the expectation that they will apply for coverage successfully.

The Florida KidCare program partners continue to conduct outreach for new enrollment, but also are focused on retention to ensure continuity of care. The Florida KidCare Evaluation Work Group directed the University of Florida's Institute for Child Health Policy to conduct focus groups with families of children whose Florida KidCare coverage was canceled for nonpayment of premium or noncompliance with renewal requirements to identify possible strategies to improve retention efforts. Families of children with special health care needs will be included in the research to determine if they face additional challenges that may require different strategies.

As a result of the Affordable Care Act requirement that children with family incomes between 100 percent and 133 percent of the federal poverty level are Medicaid eligible, it is expected that more school-age children will obtain coverage. Previously, children ages 6 through 18 with family incomes above 100 percent of the federal poverty level had to pay a monthly premium to obtain subsidized Florida KidCare coverage. Although the Department of Children and Families automatically notified Florida KidCare when children lost Medicaid due to over-income, and Florida KidCare sent notices to these families that they could keep coverage by paying the monthly premium, only about 7 percent paid the premium and received CHIP coverage. Based on early enrollment indicators, it appears that, although the monthly premium was only $15 for all children in the family, the cost may have been a barrier for some families whose incomes were closer to the federal poverty level. In the first three months of the new ACA Medicaid eligibility category for school age children with family incomes between 100% and 200% of the federal poverty level, enrollment already exceeds 50,000 children.

In August, 2014, the CMS Network will be available as a statewide Medicaid Managed Assistance plan for children with special health care needs. This will allow Title XXI-funded and Title XIX-funded children whose families choose the CMS Network as their child's plan to maintain continuity of care, regardless of changes in family income that cause them to move between the two funding sources.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	89	90	65	67
Annual Indicator	85.9	85.9	63.2	63.2	63.2
Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	69	71	73	75	77

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

CMS area offices in various areas continued to provide specialty services through telemedicine. The clinics included neurology, genetics, nutrition, and dermatology in the southeast Florida area. The University of Florida continues to provide endocrinology and genetics consults and follow-up with other areas of the state through telemedicine. Discussions continued to increase telemedicine clinics in areas where access to specialty care is hampered by distance required for travel or the wait time it takes to schedule an appointment and be seen by the physician.

CMS also used their video conferencing equipment statewide for regional meetings and educational presentations. This saved travel time and costs for CMS staff and medical directors.

The CMS on-line, web-based provider application process continued to decrease the time required for enrolling new providers. The on-line application process started during the summer of 2008 and has continued to be refined. Feedback from providers was very positive.

CMS continues to partner and collaborate with other agencies and organizations to help families navigate the system of care more easily. One example is the partnership with the Department of Children and Families where outreach has been provided to families who participate in the Medical Foster Care Program so they are successful in caring for medically complex children.

The CMS activities support: caregivers and partners; children, teens, and young adults; family leadership programs; family organizations and initiatives, and promotes the use of telemedicine. These activities provide direct health care, enabling, population-based, and infrastructure building services.

The CMSN provides telemedicine services with access to specialty services in underserved areas of the state. Telemedicine specialty care services include endocrinology/diabetes care, genetics, nutritional counseling, neurology, and dermatology. Many parents report that telehealth services allow for better access to services, decrease cost and time for travel, and decrease wait times to see a specialist. CMS continues to use video conferencing equipment for CMS meetings and educational presentations to minimize travel time and costs whenever possible.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish and maintain CMS Programs that support all caregivers and partners.				X
2. Support children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders.			X	
3. Promote use of telemedicine.		X		
4. Support family organizations/initiatives as they engage families of children at risk for and with special health care needs in effective partnerships.			X	
5. Evaluate the potential benefit of telehealth and telemedicine services for CMS enrollees and their families.	X			
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on community-based service systems.				X
7. Provision of a Pharmacy Benefits Program to CMS enrollees.	X			
8.				
9.				
10.				

b. Current Activities
The Institute for Child Health Policy (ICHP), University of Florida, continues to conduct annual satisfaction surveys from randomly selected parents of CMS enrollees.

In 2013, DOH, CMS Program served on the Multisystem Subcommittee of the Governor's Children's Cabinet. This subcommittee works to coordinate services for children who are served by one or more agency. An Interagency Agreement has been implemented to collaborate with the Department of Children and Families, the Agency for Persons with Disabilities, the Department of Education, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Guardian ad Litem Program, to look at ways to ensure well organized and easy to access to community-based service systems for children and youth including those with special health care needs and their families.

In 2013, CMS Program supported and participated in the Family Café Annual Conference. This conference brings together state agencies and families for the goal of a one stop shop for families to learn about resources and to receive information in a three day conference. The Surgeon General provided the keynote address at the conference regarding Healthy Weight.

c. Plan for the Coming Year
CMS will continue gathering quarterly data reports from CMS area offices to measure and analyze success with its six goals on a community, regional, and statewide basis as well as in comparison with national data. ICHP will continue to conduct telephonic satisfaction surveys for CMS.

CMS will continue to provide telemedicine specialty clinics through two-way interactive video teleconferencing. The telehealth program benefits CMS children and families by reducing travel time, costs, and inconvenience. Access to specialty care is improved by reducing wait times. CMS will continue to evaluate ways in which to expand telemedicine services.

CMS will continue to use the web-based provider application process to increase CMS Network provider participation, and enhancements will be made to the system in 2013-2014. The Department of Health, CMS Program will continue to serve on the Multisystem Subcommittee of the Governor's Children's Cabinet.

CMS has partnered with Department of Children and Families, the Agency for Persons with Disabilities, the Department of Education, and the Agency for Health Care Administration, and the Guardian ad Litem Program to conduct a Rapid Improvement Process (RPI) on the Children's Multidisciplinary Assessment Team (CMAT) process. This RPI will provide an opportunity for the state agencies to evaluate and make revisions if needed to assure that the families of medically complex children understand their choices in providing care for their child.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	36	34	36	38	40
Annual Indicator	33.8	37	37	37	37

Numerator					
Denominator					
Data Source	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	40	42	44	46	48

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
CMS enrollees from 12 to 21 years of age continued to receive information and resources related to transition from their care coordinator. This activity was documented in the child's CMS electronic records. Each CMS area office or region has a transition liaison that serves as a point of contact for CMS and participates in quarterly transition conference calls to link CMS care coordinators with transition experts.

CMS continued to contract for transition related activities with the Jacksonville Health and Transition Services program (JaxHATS), and the Florida Health and Transition Services program (FloridaHATS). The JaxHATS program provided clinical services for 142 patients, age 16-21 in state fiscal year 2012-2013. In addition to health-related services, JaxHATS provided or promoted skill-building strategies to help patients achieve greater independence and decision-making skills; collaborated with schools, agencies, and community resources on transition related activities; and referred patients to specialty physicians and adult providers.

The FloridaHATS program provided leadership for three community-based healthcare transition coalitions that have built community relationships, promoted their ability for providers to offer health services for adolescents and young adults; developed a directory of available primary care and specialty physicians around Florida for individuals who are transitioning from pediatric to adult providers; and developed informational brochures on health insurance. CMS entered into a Memorandum of Agreement with the Florida Association of Community Health Centers (FACHC) to ensure a smooth transition when CMS enrollees age out of CMS if they receive primary care services from a local Federally Qualified Health Center (FQHC).

The CMS health care transition website maintains pdf files for health care transition-related brochures as well as links to health care transition websites, including FloridaHATS, JaxHATS, the University of South Florida's Project 10, and the national center for health care transition, "Got Transition?". The website serves as a state and national health care transition resource with new and updated resources added.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Plan for the eventual transition of all teens and young adults with special health care needs to adult services.		X		
2. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.		X		
3. Create and maintain a Transition Guide on the CMS Internet.				X
4. Participate in a collaborative partnership with community			X	

organizations and state agencies to support the New Freedom Initiative and the Healthy and Ready to Work Transition services and systems.				
5. Create and maintain a CMS Youth Advisory Board staffed by CMS enrollees who are between 12 to 21 years of age.				X
6. Data collection and analysis from each CMS area office for CMS Goals/Performance Measures on youth transition.				X
7. CMS Transition Liaisons facilitate communication and link CMS care coordinators to transition experts to improve the transition service delivery system.			X	
8. Health care transition services provided to Youth and Adolescents with Special Health Care Needs by the Health and Transition Services providers.	X			
9.				
10.				

b. Current Activities
The JaxHATS and FloridaHATS contracts remain active. These contracts provide CMS enrollees, families, and staff with a variety of health care services and resources related to all aspects of transition.

Each CMS Area Office has an assigned care coordinator or supervisor acting as the Transition Liaison for their office. Transition-related information is sent by the CMS Central Office to the Area Office Transition Liaisons for distribution to the other CMS staff. This is an effective way of sharing important transition information statewide within CMS.

CMS transition collaborative partners continue to include the Department of Education, the Division of Vocational Rehabilitation, the Agency for Persons with Disabilities, the Department of Children and Families, the Department of Juvenile Justice, and the Agency for Health Care Administration.

c. Plan for the Coming Year
CMS will continue to work with the JaxHATS and FloridaHATS programs to develop effective health care transition delivery systems. FloridaHATS is expanding coalition efforts in Miami-Dade that will be operational by the end of FY 2013/2014. FloridaHATS and CMS continue to work with the FACHC and the FQHC's to develop more options for health care transition for adolescents and young adults with special health care needs. FloridaHATS will present to the FACHC 2014 Clinicians Network Educational Conference in an effort to increase collaboration between local FQHCs and CMS area offices. FloridaHATS continues to conduct meetings of the Medical Advisory Committee to discuss health care transition issues with health care providers and promote community-based transition collaboration around the state. The CMS statewide Health Care Transition Consultant has identified "physician champions" across the state in an effort to encourage implementation of transition programs and education at all levels of care.

CMS is collaborating with transition partners to review and update transition training modules, resources, and tools for CMS clients, caregivers, and other transition stakeholders throughout the next fiscal year. CMS will host meetings with transition partners to discuss opportunities for health care transition delivery system development. CMS will utilize the new electronic documentation system and care coordination guidelines to focus on medical home and transition. CMS continues to expand its role as a national health care transition resource and best practice by providing leadership and technical assistance to local, state, and national partners and organizations.

The Title V CSHCN's Director will present the keynote address at the second annual meeting of

the MCH funded Training Programs. The topic for 2014 will be Health Care Transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	81.9	81.1	86.1	83.0	86.7
Numerator	195839	187679	190618	178050	184876
Denominator	239120	231417	221391	214519	213237
Data Source	DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children	DOH Survey of Immunization in 2-Year-Old Children
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

The following initiatives were designed to improve immunization coverage levels in 2-year-old children: the department's missed immunization opportunities policy; outreach clinics; linkages with WIC; community partnerships and immunization coalitions; coordination with Healthy Start and managed care organizations; promotion of the Standards for Pediatric Immunization Practices in the private sector; measurement of immunization coverage levels in public and private site reviews; outreach and increased enrollment in Medicaid and SCHIP; and continued implementation of the Vaccines for Children Program. Activities performed that impact this measure generally fall within the category of population-based services, offering disease prevention interventions to the entire population. Changes in immunization rates of 2-year-old children can be attributed to the following: immunization registry implementation reaching more private health care providers and ongoing partnerships with WIC in all local health departments.

Data for CY2013 indicates that 86.7 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; one measles, mumps, rubella; three Haemophilus Influenza B; three hepatitis B; and one varicella immunizations (4-3-1-3-3-1 series). The Immunization Section shipped 4.9 million doses of vaccine to over 1,800 public and private healthcare providers. Florida SHOTS (statewide immunization registry) is functional in all 67 local health departments, for approximately 8,000 healthcare providers and includes almost 1,100 partners who have uploaded over 33 million records. Florida SHOTS is available for enrollment to private healthcare providers, schools, and licensed childcare centers. The registry includes approximately 15.8 million patient records. Additionally, the majority of school districts in Florida have schools that participate in the program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recommend all health care providers implement the Standards for Pediatric Immunization Practices.				X
2. Continue implementation of the registry (Florida Shots) in the private sector.				X
3. Implement/Continue missed opportunities policy for public and private health care providers.			X	
4. Continue WIC/Immunization linkage.		X		
5. Statewide initiative to improve collaboration with public and private stakeholders/partners in order to increase immunization coverage levels in this target population.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY2014, we continue activities to meet and surpass the state and national goal of 90 percent of all 2-year-old children who are appropriately immunized with the complete 4-3-1-3-3-1 series statewide. Specific activities include parent education; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population. Local health

departments work with WIC, local medical societies, CMS, and others to develop/implement their immunization plans.

c. Plan for the Coming Year
Our objective for CY2015 is that 90 percent of 2-year-olds receive age-appropriate immunizations. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start and Immunization coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all healthcare providers implement the Standards for Pediatric Immunization Practices, and continue expansion of the registry (Florida Shots) to include vaccine ordering and inventory capabilities. The department will continue an active partnership with coalitions and service agencies. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	17.5	15	13.4	11.9
Annual Indicator	17.6	15.3	13.4	12.0	10.5
Numerator	6261	5398	4723	4219	3698
Denominator	355066	352069	353110	352066	352403
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10.2	10	9.8	9.6	9.4

a. Last Year's Accomplishments
Final data for 2013 indicate a birth rate of 10.5 per 1,000 for teens 15 to 17, which is below the annual performance objective of 11.9 per 1,000. The Family Planning, Adolescent Health, Abstinence, and Comprehensive School Health Programs share the responsibility of providing reproductive health care services to teens throughout the state. The Family Planning program provided an array of services to teenagers beginning with preconception risk assessment,

reproductive health planning, counseling, dispensing contraceptive methods when requested, screening for sexually transmitted disease, and pregnancy testing.

Florida statute authorizes the Department of Health to make comprehensive medical knowledge, assistance, and services relating to the planning of families and maternal health care available to citizens of childbearing age. The overall program goal is to improve the health of women and children by reducing unplanned pregnancies and promoting positive pregnancy outcomes. The program works to improve maternal and infant health; lower the incidence of unintended pregnancy, including teen pregnancy; reduce the incidence of abortion; and lower rates of sexually transmitted diseases, including HIV.

The Adolescent Health Program is designed to enhance skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations. The program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. Sponsored programs reinforce positive attitudes, healthy behaviors, and activities, as well as reduce risk-taking behaviors such as sexual activity, substance abuse, suicide, and behaviors that increase risk of unintentional injury and chronic disease.

During the FY2013 school year, 46 of the 67 local health departments provided Comprehensive School Health Services Programs in 520 schools, serving 391,744 students in high-risk communities with high teen birth rates. Comprehensive school health programs are designed to provide services that improve student health, reduce high-risk behaviors, and reduce teen pregnancy. The birth rate for comprehensive school health 6th -- 12th grade females was 7.15 per 1,000. Services to address the birth rate in school-age children include maintenance of high levels of school nursing services, including nursing assessments; referral and case management; health education classes; and prevention interventions. These projects provided 532 pregnancy prevention interventions to 2,768 students and 2,138 pregnancy prevention classes to 46,590 students. A total of 427 referrals were made for aftercare and support services coordinated through Healthy Start and school district Teenage Parent Programs. These services enabled 78 percent of parenting teens to return to school after giving birth. Both Healthy Start and Teenage Parent Programs provide these parenting teens with counseling to prevent repeat births..

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Teen pregnancy prevention classes and community service learning projects conducted in several non-metropolitan communities		X		
2. Conducting abstinence-only education classes.		X		
3. Developing community and Department of Health program collaboration.				X
4. Promoting consumer involvement.			X	
5. Provision of confidential family planning counseling and education.		X		
6. Provision of confidential family planning comprehensive contraceptive services.	X			
7.				
8.				
9.				
10.				

b. Current Activities
The Teenage Pregnancy Prevention Tier 1 Grant is a five-year grant with $3,565,351 awarded per year. The program is working with the University of South Florida, College of Public Health to implement the Teen Outreach Program in 23 non-metropolitan counties within public high schools in Florida. The University of South Florida is conducting a rigorous, experimentally designed evaluation over the five-year period of this grant. The Teen Outreach Program is an evidenced-based program shown to reduce birth rates, school suspensions, and school drop-out rates amongst participants.

The Adolescent Health Program also receives a Title V Abstinence Education Grant in the amount of $2,878,201 per year for five years. The grant funds community-based organizations, faith-based organizations, and local health departments to conduct abstinence education activities in their communities. The funded providers are using evidence-based models, and are evaluated to ensure curriculum fidelity.

c. Plan for the Coming Year
Family planning, positive youth development education, and school health programs are critical components of the department's plan to reduce the birth rate for teens 15 to 17. Local health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum women about extended family planning services. These providers will have access to applications and information brochures to increase awareness and use of family planning services under the Family Planning Medicaid Waiver program. We anticipate a reduction in the number of subsequent births to teens who access and utilize family planning services.

The Adolescent Health Program will continue to manage grants for locally funded projects that deliver positive youth development education.

The Comprehensive School Health Services projects will continue to provide pregnancy prevention classes, case management, and aftercare services that enable parenting students to return to school and graduate. These projects will continue to coordinate activities with local health department abstinence programs, school district educators, local health department Healthy Start programs, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Family Services. Local health departments will continue to facilitate access to services for youth, and continue to collaborate with other community agencies on teen pregnancy prevention in their communities. Programs within the department that serve youth will continue to develop strategies to reduce the rate of births to teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	39	40	14	14.1	14.2

Annual Indicator	13.9	13.8	14.6	15.6	17.6
Numerator	11801	12515	13516	16531	19615
Denominator	84651	90882	92889	106218	111259
Data Source	DOH Public Health Dental Program	DOH Public Health Dental Program	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH	Agency for Health Care Administration/DOH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	17.9	18.8	19.7	20.6	21.5

Notes - 2011
2011 data is an estimate based on 2010 data because data for 2011 is not yet available to the Public Health Dental Program from the Florida Medicaid Program.

a. Last Year's Accomplishments
During 2013, the Department of Health (DOH) analyzed sealant data entered as Medicaid claims and also data reported by local health departments as part of a statewide database for reporting services delivered at local health department dental clinics and school-based sealant programs. The DOH was able to establish annual performance objectives and annual indicator data for years 2011-2013. Data reported for these years reflects final figures for dental sealants placed on any permanent molar tooth of Medicaid eligible eight year old children during this time period.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the development of school-based sealant programs.				X
2. Promote increased sealant utilization in local health department safety net programs.	X			
3. Develop and maintain sealant promotional material on Internet site.			X	
4. Promote the development of a surveillance system to capture sealant utilization data on permanent molars of third and ninth graders.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Public Health Dental Program continues to promote the development of school-based sealant programs and the early placement of sealants on permanent molars at local health department dental clinics. The department provides links on its Internet website where sealant promotional material can be obtained and locations of local dental providers. The department continues to support oral health objectives outlined in the State Oral Health Improvement Plan that relate to increasing the number of school-based dental sealant programs. A HRSA Grant to States to Support Oral Health Workforce Activities was awarded in 2009 through which an education and prevention specialist position has been established. A HRSA Grant to States to Support Oral Health Workforce Activities awarded in 2010 supports the funding of additional dental sealant programs provided through local health departments. In 2013, the department provided funding to 12 local health departments for the expansion of school-based and school-linked sealant projects, and over 6,200 children received dental sealants.

c. Plan for the Coming Year

The Public Health Dental Program (PHDP) will continue to promote and financially support the development and expansion of school-based sealant programs through federal and state funding. The PHDP will continue to collaborate with the school health program to increase the number of schools implementing school-based sealant programs throughout the state. A pilot project utilizing a van for transporting portable dental equipment across multiple counties in an underserved and rural region of the state, will be employed for expanding school-based sealant programs to children in counties of greatest unmet need for dental services. We expect this project will provide dental sealants to over 2,500 children across a five county area during the 2014-15 school year.

The Public Health Dental Program conducted a Third Grade Surveillance Project in 2013 and collected dental data on approximately 2,100 children to assess the oral health status and number of dental sealants on molar teeth of third grade children. This data will direct strategic planning efforts for improving preventive dental care services and increasing the number of dental sealants provided for all children in the state.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.9	1.7	1.6	2	2
Annual Indicator	2.1	2.0	2.1	1.8	1.9
Numerator	72	64	69	60	62
Denominator	3422460	3261716	3274059	3303959	3324732
Data Source	DOH Office of Vital Statistics.	DOH Office of Vital Statistics	DOH Office of Vital Statistics	DOH Office of Vital Statistics	DOH Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.8	1.7	1.6	1.5	1.4

a. Last Year's Accomplishments

The Department of Health (DOH) Injury Prevention Program is the lead agency for Safe Kids Florida, part of the Safe Kids Worldwide Campaign, a global effort to prevent unintentional injuries to children 14 and under. In 2012, over 87 percent of children 14 and younger in Florida live in a county where Safe Kids 11 local coalitions and six state chapters are operating. Florida's Safe Kids chapters and coalitions were active in child passenger safety by distributing child safety seats, training Child Passenger Safety Technicians, and launching public awareness campaigns. In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties, which corresponds to 110 fewer deaths than expected had the fatality rates been the same. In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 47.3 percent lower than the rate in non-Safe Kids counties, which corresponds to 191 fewer deaths than expected had the fatality rates been the same.

The Bicycle Helmet Program was administered through a grant from the Florida Department of Transportation from 2000--2001 and from 2004--2011. The program utilized community partners to fit and distribute thousands of helmets to children in low-income households throughout Florida. Prior to distributing helmets, the community partners received bicycle safety education and training on the correct fit and proper positioning of helmets.

Since the program's inception at the Department of Health, over 159,100 helmets have been distributed statewide through the Bicycle Helmet Promotion Program, representing a total benefit to society of over $92,300,600 (based on a Children's Safety Network Report). At the end of 2011, the Florida Bicycle Helmet Promotion Program was moved to the University of Florida Pedestrian and Bicycling Safety Resource Center and is no longer administered by the Injury

Prevention Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through the local Safe Kids coalitions and chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National Safe Kids Week, and Buckle Up America Week.		X		
2. Through the local Safe Kids coalitions and chapters, implement the Battle of the Belts program, developed in an effort to increase safety belt use amongst teenagers.		X		
3. Through the local Safe Kids coalitions and chapters, implement International Walk to School month to promote health and safety for kids walking to school.		X		
4. Through the local Safe Kids coalitions and chapters, implement the federal Safe Routes to School (SRTS) program, including Walking School Buses and Bike Rodeos (Department of Highway Safety and Motor Vehicle s and Florida Highway Patrol).		X		
5. Through the local Safe Kids coalitions and chapters, implement the 2012 Never Leave Your Child Alone in a Car Campaign.		X		
6. Through the local Safe Kids coalitions and chapters, train Child Passenger Safety Technicians to conduct car seat check-up events.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Through the 11 local Safe Kids Coalitions and seven chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National Safe Kids Week, and Buckle Up America Week. In 2012, the Florida Distracted Driving Policy Subcommittee supported the Florida Booster Seat Coalition by hosting numerous booster seat give away events.

The DOH Injury Prevention Program has a representative on numerous committees and coalitions dedicated to reducing injury and death from motor vehicle crashes. These include the Florida Teen Safe Driving Coalition, the Florida Highway Safety Strategic Planning Committee, the Florida Traffic Records Coordinating Committee, the Florida Safe Mobility for Life Coalition, the Florida Bicycle/Pedestrian Safety Committee, the Florida Distracted Driving Coalition, and the Florida Impaired Driver Coalition.

The 2009-2013 Florida Injury Prevention Strategic Plan encourages evidence-based interventions to address motor vehicle injuries due to distracted driving, a leading cause of death and injury among children in Florida. The Florida Injury Prevention Advisory Council, Strategic Plan Goal Team Leaders and Teams are an important part in the successful implementation of Florida's plan.

c. Plan for the Coming Year

The Injury Prevention Program is closing out the 2009-2013 Florida Injury Prevention Strategic Plan and creating the 2014-2018 plan. Safe Kids Worldwide has increased their focus group area to include children 19 and under. An added goal for the next plan cycle is distracted driving prevention to protect our teenage population. In 2012, the National Highway Traffic and Safety Administration reported that 10 percent of all drivers under the age of 20 involved in fatal crashes were reported as distracted at the time of the crash. This age group has the largest proportion of drivers who were distracted. Drivers in their 20s make up 27 percent of the distracted drivers in fatal crashes. Florida amended their Uniform Crash Report in 2011 to be able to capture state specific distracted driving crash data in the future.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38.5	39	39.5	40	46.5
Annual Indicator			39	46.2	40.9
Numerator					
Denominator					
Data Source	CDC National Immunizatin Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual	41	41.2	41.4	41.6	41.8

Performance Objective					

Notes - 2013
The Department of Health does not track breastfeeding data in the general population. The Department uses data provided by CDC. The data above is from the CDC Breastfeeding Report Cards which reports provisional data from the National Immunization Survey (NIS).

Breastfeeding Report Card date	Provisional data from National Immunization Survey
2009	2006 births
2010	2007 births
2011	2008 births
2012	2009 births
2013	2010 births

Notes - 2012
The Department uses data provided by the CDC based on the National Immunization Survey.

Notes - 2011
The Department uses data provided by the CDC based on the National Immunization Survey. The CDC data is based on children born in 2008 and interviewed through November 2011. The latest provisional data currently available on the CDC website is for 2008 births. Final data becomes available in August 2012.

a. Last Year's Accomplishments
The Department of Health provides breastfeeding promotion and support activities through a number of different programs including WIC, the Child Care Food Program, Healthy Start, and the Bureau of Chronic Disease. Activities target both the population at large as well as specific subsets of the population, such as WIC or Healthy Start clients.

The Department of Health does not track breastfeeding data in the non-WIC population. Provisional data from the CDC National Immunization Survey, which tracks data by birth year, indicates that 40.9 percent of all infants in Florida were being breastfed at six months of age. While this did not meet the objective that had been based on the 2012 data, it is more consistent with previous years' data. The Florida WIC program and local WIC agencies track WIC breastfeeding rates monthly. This data helps us assess our progress in improving breastfeeding rates during the year.

WIC continued participation in the U.S. Department of Agriculture (USDA) breastfeeding peer counseling program. The Florida WIC Program is in its ninth year of receiving a USDA grant for the program. Breastfeeding peer counseling funding decreased again from the previous grant year. Services have been established in all 43 local WIC agencies to provide breastfeeding promotion and support above and beyond what the regular WIC grant could accomplish. However, because of the cuts in funding, peer counseling hours were cut and peer counseling services were more limited than previously. According to data in the WIC Data System, there were about 150 individuals that were paid by the breastfeeding peer counseling grant. In addition to staffing cuts due to decreased funding, there is also an ongoing challenge to retain experienced peer counselors. From October 1, 2012 to September 30, 2013, peer counselors provided 203,947 individual services and 21,587 individuals attended classes. The program continues to meet the Loving Support(c) Through Peer Counseling requirements and targets prenatal and postpartum women.

The Florida WIC program continued to sponsor the Florida Breastfeeding Coalition monthly conference calls. The state WIC program purchased and distributed World Breastfeeding Week kits to the local WIC agencies for use in promoting World Breastfeeding Week 2013.

The WIC program continues to promote the WIC food packages and policies in support of exclusive breastfeeding. Breastfeeding pamphlets and WIC check envelopes with a breastfeeding message are given to pregnant and breastfeeding clients.

The Department of Health requires that each local health department establish and adopt a written policy that protects, promotes, and supports breastfeeding as the preferred, normal method of infant feeding. A new policy was issued which addressed telework and on-call pay for breastfeeding peer counselors. Breastfeeding education and support is one of the services offered through the Healthy Start program.

According to an evaluation study done of Florida WIC data between 2011 and 2013, 77 percent of prenatal WIC participants initiated breastfeeding. Among those who initiated breastfeeding, 64 percent received breastfeeding peer counseling services. After adjusting for factors known to be associated with breastfeeding, prenatal WIC participants who received breastfeeding peer counseling services were 27 percent more likely to initiate breastfeeding compared to participants who did not receive breastfeeding peer counseling services. Prenatal participants who received prenatal and postnatal peer counseling services were 16 percent more likely to breastfeed six months or more compared to those who did not receive peer counseling services.

In July 2013, Florida began a pilot of FL-WiSE, a new WIC data system, and providing WIC food benefits through an Electronic Benefits Transfer (EBT) system with statewide implementation planned for Federal Fiscal Year (FFY) 2014. WIC agencies will transition from paper records to electronic records. Computer screens in FL-WiSE were revised for better documentation of breastfeeding contacts. Several of the positive outcomes include: breastfeeding notes are able to be viewed by all staff doing nutrition and breastfeeding counseling. Clients have more flexibility in the timing of their food purchases. Nutritionists are able to see what foods the clients actually purchased and to promote healthy food choices.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Tracked Infants Ever Breastfed rates and Infants Currently Breastfed rates and the Percentage of WIC Breastfeeding Women/Total Infants for WIC.				X
2. Sponsored monthly telephone conference calls for statewide Florida Breastfeeding Coalition group to support coalition activities.				X
3. Sponsored monthly telephone conference calls for statewide WIC breastfeeding coordinators to share breastfeeding promotion and support activities and ideas.				X
4. Breastfeeding education and support offered through Healthy Start.	X			
5. Breastfeeding peer counselor programs now active in 43 WIC local agencies.		X		
6. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.			X	
7. Purchased and distributed World Breastfeeding Kits to local WIC agencies to assist in celebrating WBW in August 2013.				X
8.				
9.				
10.				

b. Current Activities
FL-WiSE rolled out statewide during FFY 2014. By April 2014, all WIC agencies will be using electronic health records and clients will be able to purchase WIC foods with their WIC EBT card.

Healthy Start, local health departments, WIC, and breastfeeding peer counseling staff continue to promote and support breastfeeding. WIC provides breast pumps and breast pump kits, as needed and funding is available, so women have the equipment they need to breastfeed successfully.

WIC continues to monitor breastfeeding rates. With the newly implemented FL- WiSE data system, changes in data collection and evaluation will be occurring.

WIC holds monthly conference calls with breastfeeding coordinators and peer counselor coordinators to share successful promotion and support activities. WIC provides updates on calls attended by local health department staff, Healthy Start service providers and coalition staff, and MomCare advisors. Child Care Food Program and WIC Program representatives participate in Florida Breastfeeding Coalition calls. The WIC breastfeeding coordinator participates in the Florida Network for Breastfeeding Support in the development of worksite breastfeeding support activities. WIC participates in the U.S. Breastfeeding Committee calls and its affiliate Southeast Region calls. The Bureau of Chronic Disease is working with the Florida Breastfeeding Coalition to promote the development of more certified Baby Friendly hospitals in Florida.

c. Plan for the Coming Year
For FFY 2015, WIC will focus on emphasizing strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally lower breastfeeding rates.

WIC will distribute breastfeeding equipment and information, as funding is available. WIC will continue participating in monthly conference calls with breastfeeding staff in the coming year, as well as our efforts to collect, link, and validate breastfeeding data and statistics, monitor breastfeeding rates, and evaluate breastfeeding outcomes in the new FL-WiSE data system.

The WIC program will continue to monitor the federal food packages and policies in support of exclusive breastfeeding. Breastfeeding peer counseling programs will be continued where sufficient funding is available to do so from the USDA Loving Support grant. All clients will receive WIC EBT benefits instead of WIC checks to purchase their WIC foods. WIC local agency staff will continue learning how to use, document, and view electronic records in FL-WiSE. State policies will be refined to improve use of the system.

WIC and Healthy Start will continue to coordinate their efforts so more women and families receive the education and support they need. The Department of Health will continue to promote and support breastfeeding through both local health department policies and guidelines and through the WIC and Healthy Start programs. The Department of Health will continue working with the Florida Breastfeeding Coalition on statewide breastfeeding activities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance	99	99	99	99	99

Objective					
Annual Indicator	95.5	95.9	95.8	96.5	96.4
Numerator	211357	205749	204721	205860	207821
Denominator	221391	214519	213722	213403	215658
Data Source	CMS Newborn Screening Data Base	CMS Newborn Screening Data Base	CMS Newborn Screening Database	CMS Newborn Screening Database	CMS Newborn Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments

Section 383.145, Florida Statutes, mandates that all babies born in Florida have their hearing screened prior to hospital discharge or within the first 30 days of life. The major areas of focus of the program are to: reduce loss to follow-up after failure to pass the newborn hearing screening, screen all infants for hearing loss by one month of age, diagnose hearing loss by three months of age, and enroll in early intervention services by 6 months of age. Funding for the hearing screening portion of Florida's Newborn Screening Program comes entirely from two federal grants.

A number of accomplishments occurred during the previous year. The percentage of babies screened by one month of age increased. The percentage of babies diagnosed with a hearing loss by three months of age also increased. The percentage of babies lost to follow-up/lost to documentation decreased. These improvements are the result of several activities including the implementation of a new data reporting system. Hospital staffs are now able to log into a web-based system and directly enter hearing screening results instead of recording them on a form and faxing them. About half of all facilities are trained and registered with the remaining underway.

Another effective activity has been specifically targeting certain facilities for training and technical assistance based on performance data. Data is tracked each month in four specific areas. Any facility that is outside of the statewide average by at least 20 percent receives a visit or phone call from the Hospital Hearing Educator. A total of 42 different facilities were targeted and 79 percent have already shown improvement. The remaining facilities continue to be tracked or assisted.

Eight outpatient audiology providers were recognized for excellent hearing evaluation data performance in the area of submitting diagnostic data timely. In addition, a blast email was sent to all Florida licensed pediatric audiologists as a form of outreach to improve reporting of diagnostic results for patients who did not pass the newborn hearing screening. As a result, there was an increase in the number of audiologists submitting results as well as an improvement in the

length of time from appointment date to report these results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of educational materials to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals and early intervention providers regarding universal newborn hearing.			X	
2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.				X
3. Reporting of hearing screen results on metabolic specimen cards submitted to the state laboratory.			X	
4. Running data system reports to provide statistical information regarding births and the number of babies that refer on the hearing screen.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Florida's Newborn Screening Program continues to train and register new users on the web-based data reporting system and track all facilities for performance, targeting those that do not meet expectations. The primary focus is with follow-up of 2013 patients who did not pass the newborn hearing screening. The program experienced an all-time record high of 7,986 for 2013 births, and 1,297 of them are still pending and require follow-up. The 2014 cases are also receiving follow-up, of which there are already 625 pending out of 1,431. Until recently, all hearing screening staff positions were filled and constant for over one year, but a recent resignation leaves one vacancy to be filled. The Annual Early Hearing Detection and Intervention Meeting was held in April 2014 in Jacksonville, the first time it was held in Florida. Staff prepared for this meeting, including the submission of a poster on the experience thus far on the new web-based data reporting system. An application for the Health Resources and Services Administration (HRSA) grant related to improving lost to follow-up of infants that do not pass the newborn hearing screening is being written for a new three-year cycle starting September 2014.

c. Plan for the Coming Year

Goals for the coming year included further increases in the percentage of babies screened by one month of age, the percentage of babies diagnosed with a hearing loss by three months of age, and the percentage of babies enrolled in early intervention services by six months of age. We plan to further decrease the percentage of babies lost to follow-up/lost to documentation.

Florida's Newborn Screening Program plans to start training and registration of outpatient audiologists on the new web-based data reporting system in the coming year. The program will also be migrating to an upgraded version of the newborn screening data system this summer. Per the HRSA grant expectation, a stakeholder group will be established to use the quality improvement tool Model for Improvement to help meet Florida's goals by planning a change (Plan), trying the change (Do), observing the results (Study), and acting on what is learned (Act),

or PDSA, starting on a small scale and eventually expanding strategies if effective.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18.8	16.5	16.3	14	12.5
Annual Indicator	16.7	17.8	14.3	11.8	10.9
Numerator	676000	756700	576000	529450	488010
Denominator	4046000	4242600	4042000	4486862	4477159
Data Source	US Census 2009 Estimates	US Census 2009 Estimates	US Census	US Census	US Census
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10.6	10.3	10	9.7	9.4

Notes - 2013
: US Census Bureau Estimates. 2012 and 2013 data adjusted to include 18-year-olds. Prior years did not include 18-year-olds.

Notes - 2012
: US Census Bureau Estimates. 2012 and 2013 data adjusted to include 18-year-olds. Prior years did not include 18-year-olds.

a. Last Year's Accomplishments
The Department of Health continued to work throughout the year with the University of South Florida's Covering Kids and Families (CKF) Project, the Agency for Health Care Administration, Department of Children and Families, Florida Healthy Kids Corporation, and a variety of public and private organizations to promote enrollment and retention in the Florida KidCare children's health insurance program.

The Florida KidCare partner agencies continued special outreach efforts targeted to newly uninsured children whose families lost private coverage due to job loss.

Administrative program enhancements to improve retention were a major focus. The Florida KidCare partner agencies worked to identify activities that could be accomplished without legislative action. For example, families with cell phone numbers are able to sign up for text reminders about premium payments and make the payments electronically. Simplified administrative renewals also were introduced that created pre-populated forms from data matches for families to review and sign.

In 2011, the Covering Kids and Families project received a CHIPRA Round II award to expand its

outreach efforts. Continuing its partnership with AHCA and Healthy Kids, Covering Kids projects held press conferences and participated in back-to-school events; added 47 new business partners to its existing 35 business partners; oversaw 18 "Boots-on-the-Ground" projects, and recruited and trained new partners. As part of its "CHIPRA II" grant focusing on school outreach, 19 district-wide school projects will establish sustainable enrollment and retention approaches. The English Language Learners component will focus on children enrolled in public school English as a second language program and their parents and children participating in Refugee Youth programs.

The 2012 Florida legislative session ended in early March 2012. The bill that extends Florida KidCare subsidized coverage to income eligible dependents of state employees was signed into law by the Governor. The Florida KidCare program partners also continue to work on ways to improve administrative simplification that do not require legislative action.

Florida's percentage of uninsured children has declined. Like other states, much of the success is due to the Children's Health Insurance Program and children's Medicaid. Nevertheless, the American Community Survey showed that 10.9 percent of Florida children are uninsured, compared to the national child uninsurance rate of 7.5 percent. The Florida KidCare program partners--the Department of Health, Children's Medical Services; the Agency for Health Care Administration; the Department of Children and Families, and the non-profit Florida Healthy Kids Corporation--continue to work collaboratively and with other partners to reduce child uninsurance in the state.

With the adoption of Title XXI-funded coverage for state employees' dependents, from July 2012 through December 2012, approximately 1,000 children of state employees became enrolled in subsidized Florida KidCare.

The Department of Health, Agency for Health Care Administration, Department of Children and Families, and the Florida Healthy Kids Corporation collaborate with the University of South Florida's Covering Kids and Families project and other entities to reach out to families whose children could qualify for Florida KidCare. As part of the federal CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost $1 million to the University of South Florida Covering Kids and Families (CKF) Project to help find and enroll eligible children in Florida KidCare, and to promote retention, with special emphasis on racial and ethnic minority groups whose children are more likely to be uninsured.

Florida Healthy Kids staffs subcommittees, which include Florida KidCare partner agency participation, provides advice on additional ways to improve overall program enrollment, retention, satisfaction and quality. Florida KidCare launched a smart phone application to allow a user to learn about Florida KidCare. It also sends a message to the nearest application assister to contact the family to provide additional information and assistance. AHCA started the "CHIP In" initiative, which allows organizations to provide short-term assistance with Florida KidCare premium payments for families experiencing financial difficulties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ensure families are informed that they can apply for Medicaid using the KidCare application year-round.				
2. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.				
3. Provide care coordination and other services to uninsured and underinsured families of children with special health care needs.				

4. Statewide notification of KidCare open enrollment.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As a result of implementation of the Affordable Care Act, Florida made changes to its Medicaid and Children's Health Insurance Program (CHIP). The state implemented "no wrong door" provisions, which allows an application for Family-Related Medical Assistance through the Department of Children and Families, Florida KidCare CHIP, or the federal health care portal. Other changes include simplifying eligibility and renewal by using electronic verifications through the federal hub and requesting documents only if information cannot be verified electronically; simplifying correspondence to families; and meeting regularly with Medicaid and CHIP staff to ensure children with family incomes up to 133% of poverty transitioning from CHIP to Medicaid remain with their existing providers as much as possible to ensure continuity of care.

The UF Institute for Child Health Policy analyzed the effects of child/family sociodemographic characteristics, child health status, population increases among the ages eligible for Medicaid or CHIP, and economic factors associated with disenrollment, re-enrollment, and transfer. The authors made three main recommendations: campaigns targeting Hispanics since Hispanic children had a higher probability of disenrollment; educating parents about the importance of continuity of care, even for a healthy child since healthy children had a higher probability of disenrollment; and additional projects focusing on patterns of and reasons for transfer.

c. Plan for the Coming Year
As a result of implementation of the Affordable Care Act (ACA), Florida made changes to its Medicaid and Children's Health Insurance Program (CHIP) for children's eligibility determinations. The state implemented the "no wrong door" provisions, which allow individuals and families to apply for Family-Related Medical Assistance through websites maintained by the Department of Children and Families, Florida KidCare CHIP, or the federal health care portal. Other changes include simplifying eligibility and renewal determinations by using electronic verifications through the federal hub and requesting documents only if information cannot be verified electronically; simplifying correspondence to families based on recommendations from the Maximus Center for Health Literacy; and meeting regularly with Medicaid and CHIP staff to ensure that children with family incomes up to 133% of the federal poverty level transitioning from CHIP to Medicaid remain with their existing providers as much as possible to ensure continuity of care.

In 2013, the Covering Kids and Families project applied for and received a Connecting Kids to Coverage Cycle III grant from the federal government to increase the number of application assistance center networks throughout the state where families may apply and receive assistance. Partnerships will be in geographic areas of the state with diverse populations and high rates of uninsured children who may qualify for Florida KidCare. The expansion of one-on-one application/renewal assistance best practices established under the project's Cycle I and Cycle II grants will ensure that families will have help from trusted sources within their own communities, increasing their confidence as well as the expectation that they will apply for coverage successfully.

The Florida KidCare program partners will continue to conduct outreach for new enrollment, but also are focused on retention to ensure continuity of care. The Florida KidCare Evaluation Work Group directed the University of Florida's Institute for Child Health Policy to conduct focus groups with families of children whose Florida KidCare coverage was canceled for nonpayment of premium or noncompliance with renewal requirements to identify possible strategies to improve

retention efforts.

In the fall of 2013, a new third party administrator (TPA) for Florida KidCare assumed eligibility and enrollment functions from the current TPA. The new TPA will provide additional ways for families to update accounts online, as well as continue the administrative simplification of the renewal process.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	29.4	28.7	28.5	28.2
Annual Indicator	29.6	28.9	28.8	28.3	27.8
Numerator	53043	51176	51346	49118	51146
Denominator	178926	176988	178223	173603	183974
Data Source	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services	Office of WIC and Nutrition Services
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	27.7	27.6	27.5	27.4	27.3

a. Last Year's Accomplishments
Data from Federal Fiscal Year (FFY) 2013 indicate that 27.8 percent of children ages 2-5 who receive WIC services had a BMI at or above the 85th percentile. This was below the objective of 28.2 and below last year's indicator of 28.3 percent.

A research study, Obesity & Overweight at Age Two: Risk factors among Florida WIC Participants, 2011-2013, was conducted by a student intern under the oversight of the Florida WIC epidemiologist. Study results included: Prevalence of overweight and obesity in this data set of 2-year-olds was less than the prevalence of overweight and obesity among 2-year-old WIC participants nationally. There was an increase in obesity prevalence from 2 to 3-years-olds from 9.5 percent to 13.9 percent. Children who were obese or overweight at 2-years-old are likely to remain obese or overweight at 3-years-old.

The Florida Department of Health (DOH) Bureau of WIC Program Services conducted a number of activities during FFY 2013 to continue to help reduce the number of children deemed overweight based on body mass index. A healthy weight objective for WIC children was chosen to be included in the Florida Surgeon General's Healthiest Weight initiative.

Nutrition kits continued to be developed to promote healthy lifestyles. This fiscal year's topics included milk matters, physical activity, eating healthy when eating out, saving money at the store, and using the new WIC EBT card. Included as part of these kits were lesson plans, English, Spanish, and Haitian/Creole flyers and training flipcharts, coloring sheets for children, posters, and bulletin board ideas.

The Florida WIC Program is in its ninth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. This special grant allowed expanded breastfeeding promotion and support in all counties beyond what could be accomplished with the regular WIC grant. From September 2012 to September 2013, the percentage of WIC infants who were fully breastfed at 6 months increased from 14.5 percent to 14.9 percent.

The Florida WIC Program requires local WIC agencies to develop a biennial nutrition program plan and to choose an objective in each of the following areas: nutrition education, breastfeeding, and program administration. In the nutrition program plan for federal fiscal years 2012-2013, a total of 21 local WIC agencies, which includes 35 counties, selected a nutrition education objective addressing obesity interventions for children 24 months and older. All local WIC agencies were instructed to choose a healthiest weight objective for federal fiscal years 2014-2015.

In July 2013, a new WIC data system, FL-WiSE, and WIC Electronic Benefits Transfer (EBT) were implemented as a pilot in Miami-Dade County. FL-WiSE/EBT competency-based training modules were developed and were completed by local agency staff prior to implementation of FL-WiSE/EBT in their agency. A team of state office WIC staff, including a licensed dietitian/nutritionist, traveled to grocery stores throughout the state to determine which foods would be added to the WIC Unit Product Code (UPC) database of approved WIC foods. Some of the benefits of FL-WiSE/EBT include: the following.

Electronic records allow for more accurate data recording of anthropometric measurements. WHO and CDC growth charts have been loaded and programmed in FL-WiSE for accurate plotting and viewing of growth data. BMI data for WIC children over 2 years of age will be tracked and evaluated.

FL-WiSE/EBT automates the delivery, redemption, and reconciliation of WIC benefits. EBT allows clients greater flexibility in choosing how much of their assigned food prescription they want to purchase at one time. The food prescription is assigned by a nutrition professional and is based on USDA requirements and the client's nutritional risk. Nutrition staff will have the ability to see what foods clients have purchased, which will allow nutritionists to more specifically tailor nutrition counseling to the client's needs and buying habits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to encourage local WIC agencies to use prevention of overweight as a major nutrition education focus in their nutrition education and breastfeeding promotion efforts.	X			
2. Continue to provide tools on healthy eating and physical activity for WIC families such as nutrition education materials,	X			

and nutrition education kits focusing on healthy nutrition.				
3. Continue to translate all campaign materials and nutrition education materials into Spanish and Haitian/Creole. The Hispanic population has the highest percentage of overweight children on WIC.			X	
4. Provide data to local WIC agencies each quarter which tracks the percentage of 2-5 year old WIC children who are > 85th percentile in each county.				X
5. Post all nutrition education kit information on the Intranet for other DOH staff in the state to use.			X	
6. Post nutrition campaign materials and nutrition education materials on the Internet for Floridians to use as well as other state agencies to adopt and use – www.FloridaWIC.org			X	
7. Transition all clients from paper checks to WIC EBT.	X			
8.				
9.				
10.				

b. Current Activities

FL-WiSE/EBT implementation has continued throughout the state during FFY 2014. Trainings were conducted at several locations across the state for representatives from each local WIC agency, who then trained WIC staff in their agency. Weekly training webinars were conducted to help problem solve and assure a smooth transition from the previous data system to FL-WiSE and from checks to WIC EBT. UPC data collection continued. Over 12,000 foods have been added to the UPC database of approved Florida WIC foods. One of the positive outcomes of the conversion to EBT that directly impacts overweight and obesity is that the client is able to purchase only the specific foods that have been approved by the Florida WIC Program and allowed by their food package prescription.

The nutrition education kits for FFY 2014 are on the following topics: cooking with beans, sodium, dental, and breakfast. A healthiest weight message is included on each nutrition education newsletter.

The Florida WIC Program is working with other bureaus within the Department of Health, as well as the Departments of Agriculture and Consumer Services, Children and Families, Education, and Elder Affairs to develop and distribute nutrition materials that promote a Living Healthy in Florida message. Nutritionists from the WIC Program and the Child Care Food Program served as the expert reviewers for fruit and vegetable materials that were developed as part of this initiative.

c. Plan for the Coming Year

WIC will continue to develop and distribute nutrition education kits that encourage healthy lifestyles and overweight prevention.

Living Healthy in Florida materials will be listed on the Florida WIC internet site and the website will be promoted in WIC materials. Selected flyers on fruits and vegetables will be printed and utilized with WIC clients. These materials will also be available for use by other bureaus in the Department of Health and other state agencies including Departments of Children and Families, Education, Agriculture and Consumer Services, and Elder Affairs.

Local WIC agencies will evaluate their progress in reaching their healthiest weight objective in Federal Fiscal Year (FFY) 2014. They will continue to carry out activities and evaluations planned to reach their healthiest weight objective for FFY 2015.

The final federal WIC food package regulations will be evaluated and implemented. A change that now can be implemented is to allow fat reduced milk for overweight or obese children who are between 12 and 24 months of age. With the interim regulations, children between 12 and 24 months could only receive whole milk.

The research study based on Florida WIC data, Obesity & Overweight at Age Two: Risk factors among Florida WIC participants, 2011-2013, will be presented by webinar to local WIC agencies in Florida.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.9	7.8	8.5	9.2	7.9
Annual Indicator	9.6	8.1	8.1	8.1	8.1
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	7.8	7.7	7.6	7.5	7.4

Notes - 2013
Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2011 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

Notes - 2012
Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

Notes - 2011
Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data come from the 2010 PRAMS, the last year available. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state.

a. Last Year's Accomplishments

Since 2007, when Florida's Comprehensive Statewide Tobacco Education and Use Prevention Program was established, Florida has 500,000 fewer adult tobacco users. As part of Tobacco Free Florida, Florida provides "3 Free Ways To Quit -- call, click, or come in." The Florida Quitline is available 24 hours a day, 7 days a week, offering telephone counseling in English and Spanish, and other languages through a translation service. Pregnant tobacco users who are ready to quit receive expanded services including 10 counseling sessions and with a medical release, may receive a two-week starter kit of nicotine replacement therapy (NRT). Self-help materials are also provided by mail. The Florida Quitline is one of the nation's busiest serving over 81,000 in FY2011-2012, and nearly 48,000 tobacco users accessed counseling services over the telephone.

Tobacco users may also access resources to help them quit through Florida's Web Coach online service. They can plan their quit date and even receive NRT through this free online service. Both the telephone and online services provide another feature to help tobacco users quit. Text2Quit is a new digital service that texts positive messages to tobacco users before, during, and after they quit. In its second year of operation, WebCoach served 18,890 users.

If callers prefer an in-person option, they are referred to the Area Health Education Centers (AHEC), which provide free cessation services in a group environment. In FY2011-2012, the AHECs provided over 10,000 tobacco users with smoking cessation through two different courses, Quit Smoking Now and the Tools To Quit course. The Quit Smoking Now is taught in six one-hour sessions over a six-week period and the Tools to Quit is a two-hour course. AHECs also provide training for health care professionals and students based on the Clinical Practice Guidelines for Treating Tobacco Use and Dependence. The AHECs trained health care practitioners and students to identify tobacco users and refer them for treatment each time they are seen in a clinical setting.

The Tobacco Free Florida campaign continued to educate residents on the negative effects of tobacco through a media campaign utilizing proven messages to encourage tobacco cessation. The campaign's $21 million budget is used mainly to place media, as Tobacco Free Florida uses media housed in the Centers for Disease Control and Prevention's resource center. The Tobacco Free Florida brand has over 90 percent brand recognition.

The department met quarterly with the Tobacco Education and Use Prevention Advisory Council to discuss program activities and receive advice on overall program operation. Council members represent Florida's recognized experts in tobacco control. The Bureau of Tobacco Free Florida continued to work to prevent youth and young adults from initiating tobacco use, promote cessation of tobacco use, and to eliminate exposure to secondhand smoke.

Local health departments, Healthy Start coalitions, and department staff monitored prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke. In 2012, a total of 13,949 pregnant women received 29,200 Healthy Start smoking cessation services during the prenatal period. In addition, 6,745 mothers, family members, or caregivers received 16,745 Healthy Start smoking cessation services postpartum.

Florida has been an active participant in the Collaborative Improvement and Innovation Network (CoIIN) smoking cessation strategy team. A new webpage was developed on the Tobacco Free Florida website targeting obstetric provider practitioners with information on smoking cessation reduction strategies for pregnant women. The CoIIN was instrumental in forging a stronger collaboration between department programs and stakeholders. The collaboration resulted in a partnership with the Florida March of Dimes and the Florida Association of Healthy Start Coalitions to plan for the statewide implementation of the, Smoking Cessation Reduction in Pregnancy Treatment (SCRIPT) curriculum. SCRIPT is an evidence-based program shown to be effective in helping thousands of pregnant women quit smoking. It is designed to be a component of a patient education program for prenatal care providers, and is cited by the Agency for

Healthcare Research & Quality's Smoking Cessation Clinical Practice Guidelines.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of guidelines directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring of prenatal smoking indicators by local health department and state health office staff.				X
3. Training and technical assistance on the Make Yours a Fresh Start Family program and ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking.				X
4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications.			X	
5. Monitoring of compliance with Healthy Start Standards and Guidelines standards for tobacco cessation.				X
6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking cessation and reduction of second hand smoke.				X
7. Educating the public about dangers of smoking during pregnancy and about the QuitLine using mass media.			X	
8. Enhancing preconception identification of smokers and enhanced interventions.				X
9.				
10.				

b. Current Activities
Tobacco Free Florida continues its cessation services as described in detail under Section A.

The Florida Association of Healthy Start Coalition (FAHSC) was awarded grant funding from the March of Dimes to implement train-the-trainer workshops on the SCRIPT program. The train-the-trainer workshops will be organized at five regional sites in the state and train a total of 100 staff from Healthy Start, public health and other programs that work with pregnant women and their families.

Participants who complete the training will serve as SCRIPT Implementation Coordinators for their organizations or regions. The coordinators will apply the skills from the training to: plan SCRIPT implementation, train direct care providers, order SCRIPT materials and plan SCRIPT tracking and evaluation. They will be qualified to train front-line clinical and case management staff in using SCRIPT to counsel pregnant women and their families. Training will be provided by the Society for Public Health Education (SOPHE). The department will provide SCRIPT materials for sustained implementation.

To build additional capacity and sustainability in the state, FAHSC and the department will designate staff to become Master Trainers in SCRIPT, which will enable the department to organize train-the-trainer workshops in the future. The SCRIPT Master Trainers will be trained to conduct workshops and offer technical assistance to programs implementing SCRIPT.

c. Plan for the Coming Year
FAHSC will work with the SCRIPT developers to create a Florida-specific Training and Implementation Guide to ensure program quality and effectiveness will have been completed. The guide will integrate requirements of the Healthy Start Standards and Guidelines (HSSG) for delivery of smoking cessation services.

The AHEC contracts will continue to encourage systems change activities in large obstetric practices. These activities advocate for systems change including identification and referral for tobacco users during each visit, practitioner and staff training, and information regarding free and available cessation services for their patients.

Healthy Start coalitions and local health departments will continue to encourage pregnant women and new mothers to sign up for Text4Baby. The department is currently working with Text4baby to create customized text messages specifically for Florida participants. The messages focus on various topics including resources in Florida and the effects of secondhand smoke. Funding for materials and trainings was secured. Training for trainers has been completed. The department is collaborating with the Florida Association of Healthy Start Coalitions to develop a training guide and implementation plan for the implementation of the SCRIPT program statewide.

In partnership with FAHSC, the March of Dimes and the SCRIPT developers, Florida will train at a minimum, 100 SCRIPT Implementation Coordinators through five regional workshops by June, 2015. A minimum of 500 direct service staff working with pregnant women and their families through Healthy Start, public health and other community programs will be trained on SCRIPT by June 2015. It is anticipated this effort will increase the number of smoking cessation services provided through the Healthy Start program by at least 20 percent by June 2015 (baseline: 11,940 pregnant women received 25,354 units of service in 2013 through Healthy Start).

Family planning providers across the state will screen their clients for the extent of tobacco use, and provide information on the Florida's 3 Free Ways To Quit. We will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of secondhand smoke. We will also continue to monitor compliance with the state's Healthy Start Standards and Guidelines for tobacco cessation.

Tobacco Free Florida will go through a competitive selection process during the Fiscal Years 2014-2015 Florida Quitline vendor. The plan is to use the Invitation to Negotiate purchasing process and contract for a three-year period with one renewal period. Cessation services are evolving and Tobacco Free Florida will research new opportunities as they come available and if appropriate, may make additions to the current services provided.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	6	5.8	6	7.4
Annual Indicator	6.8	4.5	6.9	8.4	6.5
Numerator	82	54	83	101	78
Denominator	1203143	1193291	1207467	1201681	1200272
Data Source	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics	DOH Vital Statistics

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6.2	6	5.9	5.8	5.7

a. Last Year's Accomplishments
Final data for 2013 indicate a decrease in the teen suicide rate from the previous year. The suicide rate per 100,000 for 15 -- 19 year-olds went from 8.4 per 100,000 in 2012 to 6.5 in 2013. There were 78 teen suicides among age 15 through 19 year-olds in 2013, compared to 101 in 2012.

During FY2013, registered school nurses and social workers provided school health services and health education to 503 schools and 349,196 youth in the state's 46 Comprehensive School Health Services Programs, and continued to assess and refer students for community-based mental health services. These registered nurses and social workers provided prevention interventions and classes in mental health; suicide prevention; violence prevention; conflict resolution; and alcohol, tobacco and other drug prevention. The Florida Suicide Prevention Coalition, which is composed of health, mental health, education, and law enforcement professionals, met and worked on strategies to identify youth at risk of suicide so they can receive appropriate prevention and intervention services. The coalition also provided information to state and local level decision makers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Suicide prevention and small group prevention-interventions and health education classes in Comprehensive School Health Services Programs.		X		
2. Youth suicide prevention train-the-trainer workshops for gatekeepers.			X	
3. Coalition building by the Florida Suicide Prevention Coordinating Council.				X
4. Utilization of proven mental health screening programs.			X	
5. Implementation of research-based suicide prevention pilot projects.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY2014, registered school nurses and social workers from the Comprehensive School Health Services Programs are continuing to coordinate with school staff and assess and refer

students for community-based mental health services. School nurses are also providing prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention. The Florida Suicide Prevention Coalition held the 12th Annual Suicide Prevention Day at the Florida Capitol on March 6, 2014. The coalition continues to meet quarterly and work on ways to identify and link youth at risk of suicide with appropriate prevention intervention services, and provide state agency and lawmakers with current information on youth suicide prevention.

c. Plan for the Coming Year

During FY2015, the registered school nurses in the states 46 county-level Comprehensive School Health Service Programs will continue to coordinate with school staff and assess and refer students for community-based mental health services. School nurses will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention. It is expected that during FY2015, the Florida Suicide Prevention Coalition will continue to meet quarterly and work on ways to identify and link youth at risk of suicide with appropriate prevention intervention services, and provide state agency and lawmakers with current information on youth suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	91.6
Annual Indicator	88.3	91.5	88.8	92.2	92.0
Numerator	3279	3157	3099	3133	3037
Denominator	3715	3452	3488	3398	3300
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	92.4	92.6	92.8	93	93.2

a. Last Year's Accomplishments

Perinatal specialists including physicians, nurses, and ancillary staff at the 11 designated Regional Perinatal Intensive Care Centers provide comprehensive high-risk obstetrical outpatient clinics to enhance care for high-risk patients. Two of the Regional Perinatal Intensive Care

Centers continue to provide obstetrical satellite clinics in five rural locations. The provision of these services increases the probability that very low birth weight infants will be born at hospitals with level III neonatal intensive care units.

Children's Medical Services registered nurse consultants and physician consultants review and monitor the Regional Perinatal Intensive Care Center Programs annually to monitor quality of care for high-risk obstetrical patients and appropriate placement for neonates in neonatal intensive care units.

Other activities include the provision of yearly educational programs to the community health providers by Regional Perinatal Intensive Care Center staff. Many Regional Perinatal Intensive Care Centers also participate in the Florida Perinatal Quality Collaborative, whose first initiative to promote no elective deliveries before 39 weeks was expanded in 2012 and 2013 through the Health Research & Educational Trust (HRET) Hospital Engagement Network (HEN) to more Florida Hospitals to assist participating hospitals in reducing early elective deliveries, including a three-year coordinated educational and communications campaign regarding the importance of the last weeks of pregnancy. The populations served are high-risk pregnant women and low birth weight/sick infants.

During 2013, a total of 92 percent of very low birth weight infants were born at high-risk facilities, a slight decrease from the 92.2 percent in 2012, but an increase from the 88.8 percent in 2011. Florida continues to strive towards meeting the goal of 92.6 percent of very low birth weight infants being born at high-risk facilities by 2018.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regional Perinatal Intensive Care Centers (RPICC) staff from two of the RPICCs provides five high-risk obstetrical satellite clinics.				
2. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic				
3. RPICC staff provides yearly educational programs to the community health providers.				
4. RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for high risk obstetrical patients and appropriate placement of neonates in the Level III NICU.				
5. Identify hospitals that are inappropriately delivering low birth weight infants, to provide education and linkage to an appropriate facility for high risk mothers and infants.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CMS and MCH goal is to ensure that high-risk obstetrical patients and very low birth weight newborns receive care at appropriate level hospitals. The Regional Perinatal Intensive Care Centers continue to provide direct health care services including inpatient services, outpatient services, and satellite clinics in rural areas.

Regional Perinatal Intensive Care Centers provide educational programs to community health providers and serve as a referral source for underserved areas.

As discussed in the last year's accomplishments section above, many Regional Perinatal Intensive Care Centers continue to participate in the Florida Perinatal Quality Collaborative and promote the reduction/elimination of early elective deliveries before 39 weeks gestation in addition to other perinatal quality improvement initiatives.

CMS also participates in the Collaboration Improvement and Innovation Network (CoIIN) to apply evidence-based strategies to reduce infant mortality. The common strategies are the promotion of smoking cessation, expansion of interconception care in Medicaid, the reduction of elective deliveries, the enhancement of perinatal regionalization, and the promotion of safe sleep.

c. Plan for the Coming Year

The goal for the coming year is to continue to support services to increase the percentage of very low birth weight infants who deliver and receive care at hospitals with level III neonatal intensive care units. Plans include the continuation of high-risk obstetrical satellite clinics, continued encouragement of participation in the Florida Perinatal Quality Collaborative by the designated Regional Perinatal Intensive Care Center staff, and the continuation of the designated Regional Perinatal Intensive Care Centers. Regional Perinatal Intensive Care Center staff will continue to provide services at their established outpatient clinics and satellite clinics to enhance access to high-risk obstetrical maternal care and education.

Children's Medical Services will continue to monitor the Regional Perinatal Intensive Care Center programs to ensure appropriate placement of neonates in the Level III NICUs. The CMS RPICC consultants will identify delivering facilities that inappropriately deliver very low birth weight neonates, and encourage the establishment of linkages necessary to transfer high-risk obstetrical women to appropriate delivering facilities.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80.5	81	81.5	82
Annual Indicator	78.3	79.3	80.3	80.0	79.9
Numerator	154752	147843	154294	159307	159880
Denominator	197693	186373	192194	199097	199996
Data Source	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	82.5	83	83.5	84	84.5

a. Last Year's Accomplishments

Final data for 2013 indicate 79.9 percent of pregnant women received prenatal care in the first trimester. This rate is lower than the 2013 performance objective of 82.0 percent. We continue to experience an increase in the number of uninsured pregnant women and a decrease in providers of prenatal care across the state.

We have encouraged local health departments to offer Presumptive Eligibility for Pregnant Women (PEPW) to assist women with early entry. Until a final determination is made, PEPW allows women to be temporarily eligible for prenatal care coverage by completing an application. One issue we are seeing around the state is that private providers are reluctant to accept the PEPW client until final Medicaid approval, thus delaying entry into care.

We worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. We continue to work with the coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen clients for Healthy Start in the first trimester. We developed policies that promote wellness among women of childbearing age, and helped educate women on the importance of first trimester entry.

Performance Improvement visits to local health departments helped staff identify barriers to first trimester prenatal care, and allowed our staff to provide focused technical assistance and training to counties with first trimester entry levels below the state average. Healthy Start coalitions provided or facilitated a variety of enabling services, depending on local needs and resources, such as translation services, outreach, health education, family support, case management, and coordination with WIC and Medicaid. All of these services help women access early prenatal care. In some communities there are few resources or options for prenatal care, especially for women who are uninsured and do not qualify for Medicaid. In these communities, the coalitions may provide financial support for the provision of direct health care services (prenatal care), as this is the only way these services are available to some of the women at highest risk.

The MomCare program, implemented statewide in FY2002, facilitates Medicaid coverage for prenatal care. MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive services. MomCare sends a packet to all clients that includes information on the Family Planning Waiver. We continued to ensure the statewide process of PEPW.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies.			X	
2. Continue focusing special technical assistance for counties with first trimester entry levels below the state average, and				X

develop and implement strategies to improve access to early prenatal care.				
3. Continue to promote the use of preconception health guidelines in the local health departments.				X
4. Continue the MomCare program.		X		
5. Continue Presumptive Eligibility and Simplified Eligibility Medicaid application processes to expedite entry into prenatal care.		X		
6. Continue working through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.				X
7.				
8.				
9.				
10.				

b. Current Activities

In January 2014, the department determined that 31 out of the 67 local health departments in the state do not offer prenatal services. Some Florida counties do not have obstetrical providers or hospitals that offer delivery services. The department's link with Florida's Healthy Start program is imperative in connecting women with prenatal care providers.

Currently, the department implements and monitors the MomCare program, as a part of the Healthy Start Program, in collaboration with Florida's Medicaid agency, the Agency for Health Care Administration (AHCA), and the Healthy Start Coalitions, who are an administrative agency by statute. Legislation that became law July 1, 2011 will move the 1915b Waiver and SOBRA (MomCare) from the department to AHCA's purview beginning July 1, 2014. The department is working closely with AHCA and coalition staff in an effort to assure a seamless transition.

The department is working with the Department of Children and Families (DCF) to educate staff and providers on the revised Medicaid application process. Pregnant women can apply for PEPW at local health departments. Qualified Designated Providers are on the integrated on-line public assistance computer system, ACCESS, which is used to determine eligibility for PEPW as well as other public assistance programs, such as food assistance, Medicaid and temporary cash assistance. Proof of pregnancy is no longer required for the PEPW application.

c. Plan for the Coming Year

The department will continue to work with the Department of Children and Families (DCF) and the ACCESS community network to educate providers on the revised Medicaid application process. We will continue to encourage local health departments to provide PEPW, allowing immediate access to Medicaid services. We will continue to work closely with the Healthy Start coalitions and DCF in addressing issues for women accessing Medicaid coverage for pregnancy, or accessing provider services once Medicaid has been approved.

Beginning July 1, 2014 the 1915b Waiver and SOBRA (MomCare) will move from the department to AHCA. Because this is part of Florida's Medicaid Managed Care Plan, the plans must establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to WIC, and the Children's Medical Services program for children with special health care needs. Each plan's programs and procedures must include agreements with each local Healthy Start coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with agency policies and the MomCare network.

Through MomCare, the network of coalitions will provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver and continue to help pregnant women in obtaining prenatal appointments and following up on their medical care. The Medicaid agency will evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants.

We will continue to work with the Healthy Start coalitions to encourage providers to see patients during the first trimester, and we will continue to partner with the coalitions to implement strategies to remove barriers and improve access to care. We will provide special technical assistance to counties with first trimester entry levels below the state average, and develop and implement strategies to improve access to early prenatal care. We will accomplish this through continued quality improvement visits to counties, as well as through working in collaboration with Healthy Start coalitions statewide.

The focus will be on areas that have access to care barriers and low continuation of prenatal care. The department will continue to encourage women to be healthy and prepared for pregnancy, and identify activities that will decrease unplanned or mistimed pregnancies. The aim is to increase community awareness of the importance of prenatal care as well as assist women in developing a support network within their community.

D. State Performance Measures

State Performance Measure 1: *The percentage of Part C eligible children receiving service*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	93.8	92.9	94.3	97.6	83.2
Numerator	33471	35223	35079	34637	24947
Denominator	35685	37907	37189	35490	29982
Data Source	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.	Early Steps Data System Annual Report.	Early Steps Data System Annual Report	Early Steps Data System Annual Report
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	98	98	98	98	98

Notes - 2013

These data include 12 months for 7 programs 3 months for 2 programs 4 months for 2 programs 1 month for 1 program and exclude 3 programs. Five local programs converted from the CMS Early Steps Data System to the CMS-KIDS data system which does not collect all service encounter data. A total of 8 programs have now converted to CMS-KIDS data system. Conversion to CMS-KIDS for the remaining programs was completed during 2013-2014.

Notes - 2012
These data include 7 months for one local program 10 months for two local programs and 12 months for the 12 remaining programs. Three local programs converted from the CMS Early Steps Data System to the CMS-KIDS data system which does not collect all service encounter data. Conversion to CMS-KIDS for the remaining programs will be phased in during 2012-2014.

a. Last Year's Accomplishments
Direct health care activities related to this measure include identifying, evaluating, and providing services to eligible infants and toddlers through contracts with 15 local Early Steps. Early Steps also provided enabling activities such as maintaining reduced caseload sizes; providing technical assistance and training to early intervention staff and providers; providing advocacy, training and support services for families; and coordinating with Medicaid and other agencies to access funding and support for the service delivery system. Population based services included providing ongoing outreach, public awareness, and education. Examples of infrastructure building activities included revision of Early Steps policies and guidance documents to ensure consistency with new requirements of the Individuals with Disabilities Education Act (IDEA) and state requirements, maintaining a centralized system for provider enrollment; collaborating with established systems for personnel development, especially with university Infant Toddler Developmental Specialist (ITDS) programs; maintaining the Early Steps Data System, and implementing quality assurance monitoring to assess performance and ensure compliance with federal regulations and state policy.

Preventing the incidence of disabilities for infants and children is a state priority. It addresses the continuing need to provide adequate screening, assessment, and services to ensure infants and children receive the services they need to help them lead more healthy lives.

In accordance with the 2004 reauthorization of the Individuals with Disabilities Education Act (IDEA), Early Steps publicly reported on statewide and local Early Steps performance. A determination of each local Early Steps was made in accordance with the provisions of IDEA and to identify local Early Steps that meet requirements and those in need of some level of assistance or intervention to meet the requirements of IDEA. Florida's Early Steps program was determined to meet the requirements of IDEA by the U. S. Department of Education Office of Special Education Programs in June 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate current service delivery system to improve services for infants and toddlers with disabilities and their families.				X
2. Provide ongoing outreach, public awareness and education.		X		
3. Identify, evaluate and provide services to eligible infants and toddlers through contracts with 15 regional programs.	X			
4. Maintain reduced service coordination caseload size at 1/65.		X		
5. Develop and implement state policy and standards for providing services in natural environments, and implement a centralized system for provider enrollment.				X
6. A Continuous Improvement system that includes Quality				X

Assurance monitoring, identification of noncompliance, technical assistance to help local programs achieve and maintain compliance, and implementation of sanctions for systemic noncompliance.				
7. Provide for an Early Steps Data System to maintain an electronic record of all children served and services provided.		X		
8. Provide advocacy, training and support services for families.				X
9. Coordinate with Medicaid, Insurance, Department of Education and other agencies to access funding and support for service delivery system.				X
10. Implement a child and family outcomes measurement system to determine the extent to which child and family outcomes are positively impacted by receipt of services through Early Steps.				X

b. Current Activities

Monitoring and technical assistance is provided to local Early Steps to promote performance, improve child and family outcomes, and ensure services are provided in accordance with federal regulations and state policy. Local Early Steps with identified noncompliance are required to develop a Continuous Improvement Plan to ensure compliance within one year. Local Early Steps with low performance on results indicators are also required to develop improvement strategies intended to improve outcomes for infants and toddlers with disabilities and their families.

In accordance with federal requirements, an annual performance report was submitted on February 2014, which includes an actual target data for July 1, 2012 through June 30, 2013.

c. Plan for the Coming Year

Early Steps will develop a new State Performance Plan which includes a State Systemic Improvement Plan. Emphasis will be placed on performance which improves results for infants, toddlers and their families in accordance with OSEP's Results Driven Accountability. Recruitment and retention of a highly qualified work force to meet the service needs of eligible children will continue be a focus, with emphasis on professional development to implement evidence-based intervention for Early Steps children and their families

State Performance Measure 2: *The percentage of births with inter pregnancy interval less than 18 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			36.6	35.2	34.9
Annual Indicator	38.2	36.9	35.7	35.3	34.2
Numerator	46307	42308	41496	42911	41996
Denominator	121282	114682	116089	121453	122652
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance	34	33.8	33.6	33.4	33.2

Objective					

a. Last Year's Accomplishments
Florida's CHARTS data for 2012 indicates that 35.3 percent of all births had an interpregnancy interval less than 18 months. The Maternal Child Health (MCH) Section, Family Planning Program, Healthy Start, MomCare, and community agencies provided an array of services to ensure new mothers have a method of contraception selected prior to the birth of the baby.

Florida statute authorizes the Department of Health (DOH) to make comprehensive medical knowledge, assistance, and services related to the planning of families and maternal health care available to citizens of childbearing age. One of the department's goals is to improve the health of women and children by reducing unintended pregnancies.

The Maternal Child Health Section continues to work with Healthy Start Coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. The MCH Section developed and implemented policies that promoted wellness among women of childbearing age and helped educate women on the importance of spacing pregnancies to have an interval of 18 months or longer between pregnancies.

The MomCare program, implemented statewide in FY2002, facilitates Medicaid coverage for prenatal care. MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive services. MomCare sends an information packet to all clients, which includes information on the Medicaid Family Planning Waiver. The Medicaid Family Planning Waiver provides family planning services for up to two years to all women who have lost full Medicaid.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide preconception and interconception care education and counseling to all clients seen in the family planning clinics.	X			
2. Provide education for family planning providers on the benefits and implementation of clients having reproductive life plans, as well as counseling techniques to encourage clients in developing individual reproductive life plan.		X		
3. Encourage local health departments to utilize the limited examination guidelines to initiate a contraceptive method without having to wait for a physical examination appointment.			X	
4. Provide emergency contraception at the county health departments.	X			
5. Encourage prenatal providers to discuss the contraceptive method that will be used following delivery by the eighth month of pregnancy.		X		
6. Ensure local health department clients (females and males) have access to and are informed about sterilization services.			X	
7. Market the availability of family planning services in isolated communities.			X	
8.				
9.				
10.				

b. Current Activities
The MCH Section continues to implement preconception health guidelines for the local DOH clinics, Healthy Start coalitions, and with local DOH family planning clinical staff.

The Healthy Start population of pregnant women and mothers of infants up to age 3 are provided information about available family planning services and where to obtain reproductive health care, including contraceptive methods. Birth intervals of 18 months or longer are encouraged during counseling and education as part of interconception counseling (Healthy Start Standards and Guidelines, Chapter 5). The MCH Section collaborates with the local DOH to expand access to a broad range of effective family planning methods and related preventive health services to include long acting reversible contraceptives.

The Florida Department of Health, MCH Section, recently partnered with the National Healthy Mothers, Healthy Baby Coalition (HMHB) to promote a free service called text4baby. With this service, expectant mothers can sign up to receive free text messages that provides them with information on a variety of maternal and child health topics. These topics include, but are not limited to, prenatal care, infant care, nutrition, and breastfeeding. The main goal of text4baby is to demonstrate the potential of mobile health technology to address maternal and child health, a critical national health priority.

c. Plan for the Coming Year
In January 2012, a group of representatives from Florida participated in an Infant Mortality Summit sponsored by the U.S. Department of Health and Human Services, Health Resources and Services Administration. The summit was held in collaboration with the Association of Maternal Child Health Programs (AMCHP), the Association of State and Territorial Health Officers, and the March of Dimes. The overall mission and goal of the summit was to improve birth outcomes and reduce infant mortality and prematurity in the United States.

The Collaborative Improvement and Innovation Network (CoIIN) was created as a result of the summit. The CoIIN goal is to reduce infant mortality and is a state-driven initiative that relies on partnership and collaboration. At this time, the CoIIN focus is on five strategic areas. These areas include: reduction of non-medically indicated early elective deliveries; enhancement of interconception care in Medicaid; reduction of sudden infant death syndrome/sudden unexpected infant death; increase in smoking cessation among pregnant women; and enhancement of perinatal regionalization. The MCH Section continues to work as a CoIIN partner to reduce infant mortality statewide.

The School, Adolescent and Reproductive Health Section (SARHS) will focus its efforts on increasing efficiency and quality of services provided on the local level. These efforts include providing technical assistance and training to local DOH staff surrounding school, adolescent and reproductive health topics. The section will also work with local DOH to ensure continued access to reproductive health and primary care services for clients. In addition, the State Adolescent Health Coordinator will continue to work on system building efforts for adolescents ages 9-18 in Florida.

The MCH section will focus efforts in those counties that have higher that the state percentage of births with interpregnancy intervals less than 18 months. The counties will be provided technical assistance to develop and implement strategies in reducing the percentage of births with interpregnancy intervals less than 18 months. The MCH Section will accomplish these efforts through performance improvement visits to counties and during quarterly conference calls, focusing on preconception and interconception care. In addition, collaboration with Healthy Start coalitions, MomCare, and other community agencies that work with mothers and babies, will ensure women are receiving services on a continuum throughout the lifespan. The MCH Section continues to promote the Medicaid Family Planning Waiver. The Medicaid Family Planning

Waiver provides family planning services for up to two years for women who have lost full Medicaid. Increased utilization of the Medicaid Family Planning Waiver expands access to effective contraceptive methods and increases the likelihood of mothers having interpregnancy intervals of at least 18 months.

State Performance Measure 3: *The percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			21	22	23
Annual Indicator	19.8	19.4	16.7	16.7	16.7
Numerator					
Denominator					
Data Source	PRAMS 2009	PRAMS 2010	PRAMS 2011	PRAMS 2011	PRAMS 2011
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	24	25	26	27	28

Notes - 2013
Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant. Most recent data available.

Notes - 2012
Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant. Most recent data available.

Notes - 2011
Data Source: PRAMS 2011 16.7 percent of all women received at least five preconception health topics before they got pregnant.

a. Last Year's Accomplishments
The department continued to participate in the Collaborative Improvement and Innovation Network (CoIIN) initiative aimed at strengthening preconception health through collaborative efforts with Title V and Florida's Medicaid agency. Activities centered on increasing the rate of postpartum visits as well as improving the quality and content of the visit to promote interconception health, particularly for women with a history of adverse birth outcomes. Staff continued to incorporate and monitor the provision of preconception health education and counseling services to family planning clients during local health department clinic visits. Staff continued to make available an online training on preconception health issues for Family Planning Waiver eligibility staff.

The department completed the process of redesigning the Healthy Start program to improve consistency of services throughout the state and ensure the use of evidence-based interventions. Preconception and interconception health were two main components included as core services to be implemented.

Florida was one of seven state teams that participated in the Life Course Metrics project designed to identify and promote a standardized set of indicators used to measure progress using the life course approach. We will use the indicator descriptive narratives to enhance efforts in completing needs assessments for our Title V and Title X grant applications. The narratives will serve as a guide to help broaden our current base of stakeholders and leverage partnerships for focus areas. They will also be used to create a statewide Life Course Indicator Report to set benchmarks that will assist MCH programmatic efforts and to conduct analyses using Florida's maternally-linked file, which links different births to the same mother using data from birth certificates, infant death certificates, hospital discharge records, and other sources.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and encourage the integration of comprehensive preconception health services for women into all health care settings.				X
2. Encourage health care providers and staff to integrate preconception education into their professional practices.			X	
3. Promote the use of preconception health guidelines in the local health departments statewide.		X		
4. Work with Healthy Start Coalitions on the provision of preconception and interconception education and counseling services throughout the state.			X	
5. Integrate preconception and interconception education and counseling into the redesign of the Healthy Start program.				X
6. Provide ongoing preconception health outreach and education through the local Healthy Start coalitions and other partners.			X	
7. Monitor the provision of preconception health education and counseling services during clinic visits to all family planning clients.		X		
8.				
9.				
10.				

b. Current Activities

The department continues to partner with the Agency for Health Care Administration (AHCA), Florida's Medicaid agency to ensure a seamless transition for clients with the July 1, 2014 transition of the 1915b Waiver and SOBRA (MomCare) to AHCA, improve services, and further enhance the quality of services to pregnant and postpartum women.

The department participates in a monthly conference call with lead persons assigned to the Collaborative Innovation and Improvement Network (CoIIN) strategic priority areas, who facilitate activities to implement each strategy. The conference calls provide updates and solicit input on the activities and strategies identified. This helps document progress, revise strategies, and brainstorm new ideas.

The department promotes reproductive life planning for all women of childbearing age as a component of primary care and promotes access to reproductive health services through the Family Planning Program.

The department completed a health problem analysis (HPA) of contributing factors to preconception health. This overarching HPA was narrowed down to the following factors: diabetes, obesity, smoking, hea

c. Plan for the Coming Year
After becoming aware of the severe impact influenza was having on pregnant women and babies in Florida, the department partnered with Florida Medicaid to temporarily activate flu vaccine payment for Medicaid recipients who are pregnant and age 21 and older. Florida Medicaid covers flu vaccines for Medicaid recipients between the ages of 18-20. The American Congress of Obstetricians and Gynecologists (ACOG), Florida District XII, collaborated with the department to disseminate statewide messages to their membership regarding an increase in the number of pregnant women with severe complications from H1N1 flu, provider alerts, information for treatment and information on the activation of Medicaid reimbursement codes for flu vaccine.

Beginning July 1, 2014, the department will offer payment for interconception services through Florida's Healthy Start program to all participants who are determined to be at high risk of a poor birth outcome in a subsequent pregnancy. This assessment will be made through the care coordination process, a referral from a medical professional or other community agency or a request for assistance from the participant. Women may be eligible for interconception services for up to 18 months postpartum. Interconception services will be provided to participants one-on-one, in groups, or in a classroom setting. This service will include information on access to care, baby spacing, family planning, nutrition, physical activity, maternal infections, chronic health problems, substance use and abuse, smoking, mental health, and environmental risk factors.

The department will work with Text4baby to create and implement customized text messages with Florida specific resources for Florida participants. This will provide the opportunity to customize messages to participants with preconception health resources in our state.

The department will begin using Life Course Indicators to create a statewide Life Course Indicator Report to set benchmarks that will assist Maternal and Child Health programmatic efforts. Additionally, the department will use the narratives to serve as a guide to help broaden our current base of stakeholders/leverage partnerships for Florida's focus areas.

The department will continue to work with the CoIIN to promote collaborative efforts between Title V and Medicaid and improve preconception and interconception health care services for all women covered by Medicaid. The department will also continue to incorporate and monitor the provision of preconception health education and counseling services during local health department family planning clinic visits.

State Performance Measure 4: *The percentage of infants not bed sharing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			78	79	80
Annual Indicator	76.9	79.3	39.4	39.4	39.4
Numerator					
Denominator					
Data Source	PRAMS 2009	PRAMS 2010	PRAMS 2011	PRAMS 2011	PRAMS 2011
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance	42	43.4	43.7	45	46.3

Objective					

Notes - 2013
2011Florida PRAMS Report

Notes - 2012
2011 Florida PRAMS Report.

Notes - 2011
2011 Florida PRAMS Report. PRAMS question: How often does your new baby sleep in the same bed with you or anyone else? Note: data prior to 2011 came from national CDC report which counts always and often as yes to bed sharing; and seldom rarely and never as not bed sharing. Florida PRAMS only counts never answers as not bed sharing which is why the percentage appeared to drop substantially between 2010 and 2011. Data for 2012 and 2013 is not available yet. We used the same information for 2012 and 2013 that we found in 2011. For the PRAMS data the numerator and the denominator are weighted to be representative of the state.

a. Last Year's Accomplishments
After conducting a health problem analysis of contributing factors to SUID, a logic model at the state level was developed to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in aligning and focusing the MCHBG activities with other initiatives such as the State Health Improvement Plan (SHIP), Infant Mortality Summit-Blue Print for Change and the Collaborative Improvement and Innovation Network (CoIIN).

The SHIP is a plan for the entire public health system--all stakeholders including state and local governments, health care providers, employers, community groups, universities and schools, environmental groups, and many more. The SHIP enables loosely-networked system partners to coordinate for more efficient, targeted, and integrated health improvement efforts; to identify priorities specific to Florida's statewide needs; to raise awareness of public health issues and stimulate increased involvement of stakeholders; to provide a common agenda for health; to link statewide efforts to national initiatives; to increase accountability; and to build collaborations that produce results. It incorporates and builds on the many activities the department has participated in during the past year including but not limited to the Collaborative Improvement and Innovation Network (CoIIN); AMCHP Initiative: Optimizing Health Reform to Strengthen Preconception Health and Improve Birth Outcomes; Maternal Mortality Initiative; Child Abuse Prevention and Permanency Plan (CAPP); and the Life Course Metrics Project.

One of the strategies of the SHIP plan was to partner with Florida's Department of Children and Families (DCF) to initiate an educational health care provider and consumer campaign on safe sleep. The department also partnered with the Ounce of Prevention Fund of Florida to accomplish this task.

In June 2010, Florida's Office of Adoption and Child Protection launched and completed the five-year CAPP plan. This five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. The plan incorporated the work of over 600 people statewide including many department staff. One strategy of the CAPP is that by June 30, 2015, Florida will have implemented selected prevention efforts based upon the findings of an All Child Death Review process that provides for the review of the deaths of all children from birth until the age of 18 who have died in Florida.

Currently, the department provides administrative oversight for Florida's Child Abuse Death Review Committee (CADR) and provides technical assistance and funding to the Fetal Infant Mortality Review (FIMR) teams. In an effort to increase collaboration between the CADR and

FIMR teams, a Memorandum of Agreement (MOA) was developed by the department for the unfunded FIMR teams in order to establish uniformity between the funded and unfunded FIMR projects. The department facilitates a quarterly FIMR conference call to provide technical assistance and to provide a forum for FIMR teams to share best practices. Also, department staff participates in the quarterly CADR meetings.

The department provided a statewide Florida-focused informational webinar on SUIDs to MCH professionals and partners that gave an overview of sudden unexpected death definition; prevalence of risk and protective safe sleep behaviors; the results of an active surveillance study on sleep-related deaths; and federal/state initiatives to reduce sleep-related infant deaths.

In April 2011, the Florida Department of Health awarded a contract to facilitate the Florida Healthy Start program redesign process. The goal of the redesign was to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components is safe sleep practices and environment.

Florida has passed a law that requires hospitals to provide safe sleep and SUID information to all new parents/guardians before newborns are discharged from the hospital. The law, Florida Statutes 395.1052, went into effect July 1, 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training on safe sleep recommendations and reasons why parents may not be following them.				X
2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues.				X
3. Provide information on safe sleep through conference calls, site visits, and meetings.			X	
4. Provide information about available written materials and DVDs on safe sleep.			X	
5. Provide training on screening and treatment for depression since depressed women are more likely to bed share.			X	
6. Provide training to law enforcement on death scene investigation.				
7.				
8.				
9.				
10.				

b. Current Activities

The department continues to participate in CoIIN activities and engage a multidisciplinary team to work on safe sleep practices and sleep environment. Information on the latest research findings and technical assistance is shared through statewide conference calls to Healthy Start and local health department staff. The department is currently developing a second informational webinar for healthcare professionals and paraprofessionals on effective community interventions to improve the competency of healthcare staff to deliver safe sleep education.

First responders are being trained in Safe Sleep practices. They are to use this knowledge to provide education in homes they go to if they see there is a baby in the home. To date, 230 first responders, 54 child welfare staff, and 38 law enforcement staff have completed the training statewide. Printed materials for parents on safe sleep are distributed to families by first

responders. Additionally, first responders will serve as a collection point for Pack 'n Plays for parents who do not have a safe place for their baby to sleep. To date, 183 Pack 'n Plays have been distributed through this initiative.

The department developed a Health Problem Analysis that examines risk factors for infant deaths, including infant sleep practices and substance exposure in utero. Direct and indirect contributing factors have been mapped out in this analysis, which is being used to further develop strategies to reduce SUID.

c. Plan for the Coming Year
Participation in the CoIIN activities will continue.

DOH has formed a Statewide SUID Workgroup. This workgroup provides input on the state work plan to reduce sleep related infant deaths, advises on prioritization of plan objectives and outcomes, assists with implementation of state work plan strategies, and monitors and reviews the work plan. This SUID Workgroup created a logic model for conducting training efforts on Safe Sleep practices for healthcare providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the general public. The Workgroup developed goals and objectives that provide education on safe sleep practices, address barriers to following safe sleep recommendations, address methodology to increase the number of hospitals implementing baby-friendly policies and practices, maps out how surveillance of safe sleep behaviors can be conducted, and measures and analyzes SUID trends and factors

In partnership with DCF and the Ounce of Prevention Fund of Florida, the department will repeat the safe sleep PSAs and will add a social media marketing campaign on SUID prevention and infant safe sleep environments. The department is in the process of developing and implementing a questionnaire for Florida hospitals regarding their safe sleep policies, and of pediatricians and family practice physicians to assess their safe sleep education to parents.

Another strategy includes the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level. Department staff will continue to participate at the CADR meetings and to host and provide technical assistance and funding to the FIMR teams. Specific strategies will be implemented and their outcomes evaluated throughout the remainder of the grant cycle and will coincide with CoIIN safe sleep activities.

State Performance Measure 5: *The percentage of infants back sleeping.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			65	66	67
Annual Indicator	61.3	65.1	67.2	67.2	67.2
Numerator					
Denominator					
Data Source	PRAMS 2009	PRAMS 2010	PRAMS 2011	PRAMS 2011	PRAMS 2011
Is the Data Provisional or Final?				Provisional	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	68	69	71	72	73

Notes - 2013
2011 PRAMS report.

Notes - 2012
2011 PRAMS report.

Notes - 2011
2010 PRAMS report.

a. Last Year's Accomplishments
After conducting a health problem analysis of contributing factors to SUID, a logic model at the state level was developed to address these risk factors with outcome measures to assess strategy effectiveness. These two documents have been instrumental in aligning and focusing the MCHBG activities with other initiatives such as the State Health Improvement Plan (SHIP), Infant Mortality Summit-Blue Print for Change and the Collaborative Improvement and Innovation Network (CoIIN).

The SHIP is a plan for the entire public health system--all stakeholders including state and local governments, health care providers, employers, community groups, universities and schools, environmental groups, and many more. The SHIP enables loosely-networked system partners to coordinate for more efficient, targeted, and integrated health improvement efforts; to identify priorities specific to Florida's statewide needs; to raise awareness of public health issues and stimulate increased involvement of stakeholders; to provide a common agenda for health; to link statewide efforts to national initiatives; to increase accountability; and to build collaborations that produce results. It incorporates and builds on the many activities the department has participated in during the past year including but not limited to the Collaborative Improvement and Innovation Network (CoIIN); AMCHP Initiative: Optimizing Health Reform to Strengthen Preconception Health and Improve Birth Outcomes; Maternal Mortality Initiative; Child Abuse Prevention and Permanency Plan (CAPP); and the Life Course Metrics Project.

One of the strategies of the SHIP plan was to partner with Florida's Department of Children and Families (DCF) to initiate an educational health care provider and consumer campaign on safe sleep. The department also partnered with the Ounce of Prevention Fund of Florida to accomplish this task.

In June 2010, Florida's Office of Adoption and Child Protection launched and completed the five-year CAPP plan. This five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. The plan incorporated the work of over 600 people statewide including many department staff. One strategy of the CAPP is that by June 30, 2015, Florida will have implemented selected prevention efforts based upon the findings of an All Child Death Review process that provides for the review of the deaths of all children from birth until the age of 18 who have died in Florida.

Currently, the department provides administrative oversight for Florida's Child Abuse Death Review Committee (CADR) and provides technical assistance and funding to the Fetal Infant Mortality Review (FIMR) teams. In an effort to increase collaboration between the CADR and FIMR teams, a Memorandum of Agreement (MOA) was developed by the department for the unfunded FIMR teams in order to establish uniformity between the funded and unfunded FIMR projects. The department facilitates a quarterly FIMR conference call to provide technical assistance and to provide a forum for FIMR teams to share best practices. Also, department staff participates in the quarterly CADR meetings.

The department provided a statewide Florida-focused informational webinar on SUIDs to MCH professionals and partners that gave an overview of sudden unexpected death definition; prevalence of risk and protective safe sleep behaviors; the results of an active surveillance study on sleep-related deaths; and federal/state initiatives to reduce sleep-related infant deaths.

In April 2011, the Florida Department of Health awarded a contract to facilitate the Florida Healthy Start program redesign process. In March 2013 the department completed the process and is currently working on the implementation phase. The goal of the redesign was to increase the delivery of effective, evidence-based services in order to improve maternal and infant health outcomes including reducing infant and maternal morbidity and mortality. One of the core components is safe sleep practices and environment.

Florida has passed a law that requires hospitals to provide safe sleep and SUID information to all new parents/guardians before newborns are discharged from the hospital. The law, Florida Statutes 395.1052, went into effect July 1, 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training on safe sleep recommendations and the reasons why parents choose not to follow them.			X	
2. Technical assistance and training on how to talk with parents and caregivers about safe sleep issues.	X			
3. Provide information on safe sleep through conference calls, site visits, and meetings.	X			
4. Provide information about available written materials and DVDs for parents and caregivers on safe sleep.		X		
5. Monitor compliance with guidelines for prenatal education regarding risk reduction for sudden unexpected infant death.	X			
6. Share best practices.		X		
7. Train law enforcement on death scene investigation.				X
8.				
9.				
10.				

b. Current Activities

The department continues to participate in CoIIN activities and engage a multidisciplinary team to work on safe sleep practices and sleep environment. Information on the latest research findings and technical assistance is shared through statewide conference calls to Healthy Start and local health department staff. The department is currently developing a second informational webinar for healthcare professionals and paraprofessionals on effective community interventions to improve the competency of healthcare staff to deliver safe sleep education.

First responders are being trained in Safe Sleep practices. They are to use this knowledge to provide education in homes they go to if they see there is a baby in the home. To date, 230 first responders, 54 child welfare staff, and 38 law enforcement staff have completed the training statewide. Printed materials for parents on safe sleep are distributed to families by first responders. Additionally, first responders will serve as a collection point for Pack 'n Plays for parents who do not have a safe place for their baby to sleep. To date, 183 Pack ‘n Plays have been distributed through this initiative.

The department developed a Health Problem Analysis that examines risk factors for infant

deaths, including infant sleep practices and substance exposure in utero. Direct and indirect contributing factors have been mapped out in this analysis, which is being used to further develop strategies to reduce SUID.

c. Plan for the Coming Year
Participation in the CoIIN activities will continue.

DOH has formed a Statewide SUID Workgroup. This workgroup provides input on the state work plan to reduce sleep related infant deaths, advises on prioritization of plan objectives and outcomes, assists with implementation of state work plan strategies, and monitors and reviews the work plan. This SUID Workgroup created a logic model for conducting training efforts on Safe Sleep practices for healthcare providers, the Florida Hospital Association and other birthing centers, parents, caretakers, and the general public. The Workgroup developed goals and objectives that provide education on safe sleep practices, address barriers to following safe sleep recommendations, address methodology to increase the number of hospitals implementing baby-friendly policies and practices, maps out how surveillance of safe sleep behaviors can be conducted, and measures and analyzes SUID trends and factors

In partnership with DCF and the Ounce of Prevention Fund of Florida, the department will repeat the safe sleep PSAs and will add a social media marketing campaign on SUID prevention and infant safe sleep environments. The department is in the process of developing and implementing a questionnaire for Florida hospitals regarding their safe sleep policies, and of pediatricians and family practice physicians to assess their safe sleep education to parents.

Another strategy includes the development of training for WIC staff to encourage discussion of safe sleep practices with their clients and continued training for Healthy Start and local health department staff on how to deliver SUID risk reduction education at the local level. Department staff will continue to participate at the CADR meetings and to host and provide technical assistance and funding to the FIMR teams. Specific strategies will be implemented and their outcomes evaluated throughout the remainder of the grant cycle and will coincide with CoIIN safe sleep activities.

State Performance Measure 6: *The percentage of teen births, ages 15-17, that are subsequent (repeat) births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			8.8	8.1	7.3
Annual Indicator	9.5	9.0	8.3	7.4	7.4
Numerator	602	486	391	314	274
Denominator	6308	5398	4723	4219	3698
Data Source	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS	Florida CHARTS
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6.7	6.3	6	5.8	5.6

a. Last Year's Accomplishments

The family planning program provided services to 11,940 teens ages 15-17 during 2013, with 25,195 visits and 81,185 services for this age group. The program provided a total of 188,965 services to 29,001 teens. Final data for 2013 indicate that 7.4 percent of teen births were repeat births, the same percentage as in 2014. The number of repeat births for this age group decreased from 314 in 2012 to 274 in 2013. The total births to teens 15-17 decreased from 4,219 in 2012 to 3,698 in 2013, which accounts for the consistent percentage despite the significant drop in the number of repeat births.

During 2012, a County Performance Snapshot Measure was initiated statewide to indicate the percentage of teens using an effective method of contraception for each local DOH. Effective methods were defined as long-acting reversible contraception (LARC), combined oral contraceptives, progestin-only contraceptives (including the contraceptive injection), the contraceptive patch, and the contraceptive vaginal ring. The local DOH were provided percentage goals for the measure. Increased use of effective methods by teens is expected to impact the repeat teen birth rates.

A Sexually Transmitted Infection grant was administered through the Family Planning Program stressing preconception health, which included gonorrhea and chlamydia testing for women less than 26 years of age. The grant ended in eight local Departments of Health (DOH) on June 29, 2013. The eight local DOH participating had high rates of gonorrhea and chlamydia. Family planning (FP) female clients under the age of 26 requesting a pregnancy test and/or emergency contraception received preconception health counseling and gonorrhea and chlamydia testing. A total of 7,286 family planning female clients received preconception health services through the sexually transmitted infection project during FY 2012-13. Decreased rates of chlamydia in the participating local DOH family planning clients, for the ages of 15-19 and for women ages 20-26, were statistically significant for both age groups from FY 2011-2012 to FY 2012-13.

Teen pregnancy prevention materials were ordered and distributed to local DOH family planning staff. The teen and young adult focused Choices magazine published by Bridging the Gap Communications, Inc., was ordered and mailed to local DOH staff for client educational materials. A total of 23,250 magazines were provided to the local DOH.

The Healthy Start population of pregnant women and mothers of infants up to age 3 were counseled about the availability of family planning services and where to obtain family planning services in order to delay repeat births. Healthy Start also offered interconception counseling as a Healthy Start service to encourage women to allow 18 months between delivery of a baby and a subsequent pregnancy.

The Adolescent Health Program implemented two initiatives during 2012, the Teenage Pregnancy Prevention Project and the Abstinence Education Program. The Teenage Pregnancy Prevention Project utilized evidence-based curriculum in 23 non-metropolitan counties with notably high rates of teen pregnancy, school drop-out, and course failure. The facilitators within the 23 counties were trained in the Teen Outreach Program, an evidence-based curriculum. Approximately 9,100 students participated in the Teen Outreach Program in 2013. The Abstinence Education Program funded 18 providers during 2013. Providers include local DOH and community based organizations utilizing evidence-based curricula with youth ages 12-19. These curricula included Project AIM, Making a Difference and Promoting Health among Teens. Programming was provided in schools, youth centers, and community organizations. Approximately 700 students were provided services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Provide confidential family planning counseling, education and comprehensive contraceptive services.				
2. Increase access to contraceptive services for teen mothers ages 15-17.		X		
3. Increase the number of sexually active teens who receive reproductive health services at family planning clinics.			X	
4. Reduce the proportion of pregnancies that were conceived within 18 months of a previous birth by providing preconception health counseling.			X	
5. Provide individual and small group pregnancy prevention interventions with Adolescent Health Services, Teen Pregnancy Prevention Grants and Healthy Start Programs.	X			
6. Provide School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.		X		
7. Collaboration of Department of Health programs striving to reduce subsequent teen pregnancy.			X	
8.				
9.				
10.				

b. Current Activities

Reproductive health education, method counseling, and family planning (FP) services are provided to all teens that request FP services. The percentage of teens that adopt an effective method of contraception in each local DOH is monitored. A special purchase of LARC totaling $250,000, and an additional purchase of $200,000, is expected to increase the number of teens using a LARC.

Local DOH and Healthy Start (HS) coalitions continue to provide interconception counseling and health care to reduce subsequent births in teens. HS caseworkers encourage pregnant teens to choose an effective method of contraception prior to delivery, and provide information regarding eligibility for the Medicaid FP Waiver. Postpartum teens are eligible for FP services through the Medicaid FP Waiver.

The FP Program office is purchasing and distributing teen pregnancy prevention educational materials. The teen and young adult focused Choices magazine is available in English and Spanish. During fiscal year 2013-14, 10,000 copies in Spanish and 10,000 copies in English will be provided to local DOH family planning clinics.

Full implementation and evaluation for the Teen Outreach Program will continue during the 2013-2014 school year. An increase in participants is expected during the current grant year. Approximately 9,000 students are expected to receive services through the Making a Difference and Promoting Health Among Teens curricula, during the 2013-2014 grant year.

c. Plan for the Coming Year

The plan to reduce subsequent births to teens ages 15-17 includes the provision of family planning services in all 67 local DOH, including: pregnancy prevention counseling; effective contraceptive method counseling and abstinence education; contraceptive services; comprehensive reproductive health education; Healthy Start services; and School Health services.

A special emphasis is planned for providing teens with highly effective methods of contraception, including long-acting reversible contraceptives (LARC). The provision of LARC to teens is a Title

X priority for 2014. The County Snapshot Performance Measure of "The Percentage of Teens that Adopt an Effective Method of Contraception" will be provided to local DOH each quarter to allow for local evaluation of the measure. Increased use of effective methods of contraception is expected to impact the repeat teen birth rates. Additional funds were requested in the 2014-15 competitive Title X Grant to purchase LARCs. In addition, the department received a special state funding appropriation for the provision of LARCs.

The Family Planning Program requested funds in the 2014-2015 Title X competitive grant to extend gonorrhea and chlamydia testing statewide for women under the age of 26 that request a pregnancy test and/or emergency contraception. The women that request a pregnancy test and/or emergency contraception will also be offered an effective method of contraception.

Educational brochures written for teens and young adults will be purchased and provided for the staff in all 67 local DOH to distribute to teens and young adults during clinic visits and community events.

Program office staff will continue to encourage local DOH staff to utilize FMMIS to identify teens that have lost Medicaid and assist them with the application process for the Medicaid Family Planning Waiver. Local DOH, local contract providers, Healthy Start programs, Healthy Families Florida programs, School Health program nurses, Healthy Start caseworkers, and other agencies that provide maternal and infant care services will provide pregnant, postpartum, and parenting teens information regarding eligibility for the Medicaid Family Planning Waiver. Youth not eligible to participate in the Medicaid Family Planning Waiver will be provided services utilizing the department's Title X Family Planning Program.

Local DOH, Healthy Start coalitions, and agencies and programs involved in welfare reform will continue to educate and collaborate with community agencies in reducing subsequent teen births.

The Adolescent Health Program's two initiatives, the Teenage Pregnancy Prevention Project and the Abstinence Education Program, continue and will be in the fifth year of five funding years. Both projects will serve adolescents between the ages of 11-19 through evidence-based curricula. These services will be provided in school, after-school, community and faith-based settings.

State Performance Measure 7: *The percentage of low-income children who access dental care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26.7	26.9	30.3	38.4	38.6
Annual Indicator	30.1	38.0	26.3	27.8	29.0
Numerator	625191	777423	594914	670173	745342
Denominator	2077021	2045849	2261437	2414583	2567729
Data Source	DOH Public Health Dental	DOH Public Health Dental	Agency for Health Care Administration	Agency for Health Care Administration	Agency for Health Care Administration

	Program	Program			
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29.6	31.4	33.1	34.9	36.6

Notes - 2013
Annual Performance Objectives Modified to better reflect trend in data source for this measure. From 2011 forward, the data source is the CMS-416 Report which is furnished by the Agency for Health Care Administration. Prior to 2011, approximations using data from several different sources were used to obtain estimates. This change in data source reflects an effort to measure the objective in a consistent way from one decision support system.

Notes - 2011
Annual Performance Objectives Modified to better reflect trend in data source for this measure. From 2011 forward, the data source is the CMS-416 Report which is furnished by the Agency for Health Care Administration. Prior to 2011, approximations using data from several different sources were used to obtain estimates. This change in data source reflects an effort to measure the objective in a consistent way from one decision support system.

a. Last Year's Accomplishments
Serving low income children under the age of 21 continues to be a statewide priority for continuing dental services provided by local health departments. Funding provided by a HRSA grant, supports local health departments to increase access to dental services through school-based sealant programs operated in 12 counties. The percentage of children receiving dental services through dental clinics operated by local health departments has increased steadily since 2011 from 26 percent to 29 percent in 2013.

Recommendations of the state oral health improvement plan for disadvantaged persons facilitated by a HRSA Targeted Oral Health Services System grant are ongoing. This broad-based initiative provides support to increase awareness of oral health issues and collaborative partnerships with state programs and local organizations to facilitate the continued development of an integrated coordinated oral health system between the public and private sectors.

Fluoridation of community water supplies continues to hold steady with 76.6 percent of Florida's population receiving dental benefits from water fluoridation. Fluoridation campaigns continue to support local communities to provide optimally fluoridated water for Florida residents. Long-term benefits of water fluoridation will continue to reduce treatment needs and improve the oral health status to Florida residents.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate the continued development of an integrated coordinated oral health system between the public and private sectors.				X
2. Conduct community-based dental projects.	X			
3. Promote increased access through local health department safety net programs.	X			
4. Promote the integration of oral health education in WIC Child				X

Nutrition and other local health department programs as appropriate.				
5. Promote the start of oral health practices in infancy and appropriate use of fluoride products throughout early childhood in conjunction with the CDC's Brush Up on Healthy Teeth campaign.			X	
6. Promote the development of community and school-based preventive and educational programs.			X	
7. Update Internet site to facilitate information exchange.				X
8.				
9.				
10.				

b. Current Activities

The Public Health Dental Program (PHDP) continues activities outlined in the state oral health improvement plan. Through a HRSA Grant to States to Support Oral Health Workforce Activities, funding helped local health departments to expand dental services and school-based sealant initiatives. Other initiatives include water fluoridation initiatives in local communities and working with the Oral Health Florida Coalition to align the state's oral health improvement plan with the Coalition's objectives to increase the percentage of people on optimally fluoridated water supplies and expand access to care through school-based prevention programs. The PHDP continues to emphasize the integration of oral health into all appropriate DOH programs through the development of protocols and preventive messaging focusing on improving dental outcomes.

The Preventive Health and Health Services Block Grant provided funding for three municipal fluoridation contracts to support the installation of equipment for improving the delivery of optimal fluoridation. The PHDP plans to initiate regional trainings with water plant operators and local county administrators to educate about the long-term benefits of optimal water fluoridation that will reduce dental treatment needs and improve oral health outcomes. The PHDP continues to work with local communities to provide resources for water fluoridation campaigns to increase the percentage of Florida's population on optimally fluoridated water.

c. Plan for the Coming Year

The PHDP will continue to promote increased access to community water fluoridation. Through the department's Reducing Oral Health Disparities initiative, the PHDP will promote increased capacity for dental services provided through local health department programs. The state's oral health improvement plan continues to prioritize initiatives focusing on increased access to dental services for low income and disparate populations.

The PHDP is planning quality improvement activities for monitoring grant activities and dental services provided by the local health departments. The PHDP will continue to provide technical assistance and guidance for program improvement and expansion of dental services.

Recently, the PHDP completed a Third Grade Surveillance Project to analyze and report on the oral health status of third-graders across the state. Later this year, a similar surveillance study is planned to assess the oral health of children enrolled in Head Start programs. In future years, data collection initiatives will be planned to track the prevalence of dental disease for various population groups including teens, adults, and the elderly to fully assess the burden of dental disease in Florida. Collaboration with internal and external partners will continue and the activities of the PHDP will focus on the development of a comprehensive oral health plan that addresses the priority oral health needs of the state. These program initiatives will lead to the expansion of dental services and improvement in the overall oral health status of the state.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	8.7	8.7	8.7	8.6	8.5
Numerator	19297	18719	18558	18291	18255
Denominator	221391	214463	213237	212954	214419
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Factors that may contribute to the risk of low birth weight and very low birth weight include mother's race, age, multiple birth, education, socioeconomic status, and substance use during pregnancy. Black infants are twice as likely as white infants to be born at a low birth weight, and black mothers accounted for 22.9 percent of resident live births in Florida in 2010. In 2010, 17.1 percent of all mothers had less than a high school education. A total of 14,946 mothers (7.0 percent) reported they smoked during pregnancy. There were 6,870 multiple births in 2010 (3.3 percent of total births).

/2014/ Black mothers accounted for 22.9 percent of resident live births in Florida in 2011. In 2011, 16 percent of all mothers had less than a high school education. A total of 14,232 mothers (6.7 percent) reported smoking during pregnancy. There were 7,183 multiple births in 2011 (3.4 percent of total births). //2014//

The department continues to promote prenatal smoking cessation through public awareness and the provision of classes, counseling and cessation methods as one of many strategies to address both low and very low birth weight. The WIC prenatal caseload has been expanded, the percentage of pregnant women whose delivery is paid for by Medicaid has been increased, and the department started new preconception health initiatives and looked at more effective ways of providing prenatal care. Family planning efforts were also strengthened, including the Medicaid family planning waiver.

Low birth weight deliveries raise the risk of infant mortality, morbidity, and developmental disability, and also cause greater health care costs. The percentage of twins and multigestation pregnancies is no longer increasing in Florida and does not contribute to these recent trends. The department has recently studied the increase in preterm and late preterm births, a major determinant of low birth weight. Approximately one-third of the increase in preterm births is related to Cesarean delivery.

/2014/ In 2011, babies weighing less than 2,500 grams accounted for 8.7 percent of all live births, with a provisional rate of 8.6 for 2012. //2014//

/2015/ In 2012, babies weighing less than 2,500 grams accounted for 8.6 percent of all live

births, with a provisional rate of 8.5 for 2012. //2015//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	7.0	7.0	6.9	6.9	6.8
Numerator	14990	14639	14215	14241	14184
Denominator	214201	207682	206097	206064	207465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HIS #01A above, except for the following data interpretation.

In Florida, singleton birth babies weighing less than 2,500 grams accounted 7.0 percent of all live singleton births in 2010, with a provisional rate of 6.9 in 2011. The difference between all births with low birth weight (8.7 percent) and singleton births with low birth weight (7.0 percent) in 2010 is attributable to multiple births. Studies have shown that more than half of twins and other multiples are born low birth weight. Previous increases in multiple births have been associated with older age at childbearing and an increase in fertility therapies.

/2014/ Singleton birth babies weighing less than 2,500 grams accounted 6.9 percent of all live singleton births in 2011, with a provisional rate of 6.9 in 2012. //2014//

/2015/ Singleton birth babies weighing less than 2,500 grams accounted 6.9 percent of all live singleton births in 2012, with a provisional rate of 6.8 in 2013. //2015//

Efforts to reduce low birth weight deliveries for all infants included the following.

/2014/ In July 2012, the department contracted with the Florida Perinatal Quality Collaborative (FPQC) to promote perinatal care quality improvement efforts. One issue of focus is to decrease non-medically indicated deliveries less than 39 weeks gestational age in at least an additional seven Florida maternity hospitals with maternity services. The FPQC has been very effective using the March of Dimes (MOD) toolkit and process and currently are working with the MOD and the Florida Hospital Association to recruit other hospitals to participate. //2014//

/2014/ The department participated with the Association of State and Territorial Health Officials (ASTHO) and the MOD challenge to reduce premature births by 8 percent by 2014. The department supported a preconception health public awareness campaign with a specific focus on healthy weight maintenance, caring for chronic conditions, pregnancy planning and the reduction of risk factors such as tobacco, drug and alcohol use. All of these efforts should increase the likelihood that every infant may be born as healthy as possible. //2014//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.6	1.6	1.6	1.6	1.5
Numerator	3544	3522	3433	3415	3293
Denominator	221391	214463	212237	212954	214419
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HIS #01A above, except for the following data interpretation.

The percentage of infants born very low birth weight in Florida has remained consistently at or near 1.6 percent since 2006. The risk of death in the first year of life for infants born with very low birth weight is more than 90 times greater than infants born at more than 2,500 grams.

/2014/ The percentage of infants born with very low birth weight remains at 1.6 percent. //2014//

/2015/ The percentage of infants born with very low birth weight remains at 1.6 percent. //2015//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.3	1.3	1.3	1.3	1.2
Numerator	2708	2674	2626	2662	2539
Denominator	214201	207735	206097	206064	207465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Same as HIS #01A above, except for the following data interpretation.

In Florida the percentage of singleton infants born very low birth weight in Florida has remained at 1.3 percent from 2003 to 2010, and the provisional rate for 2011 is also 1.3 percent. The difference between all births with very low birth weight (1.6 percent) and singleton births with very low birth weight (1.3 percent) is attributable to multiple births.

/2014/ The percentage of singleton infants born with very low birth weight remains at 1.3 percent. //2014//

/2015/ The percentage of singleton infants born with very low birth weight remains at 1.3 percent. //2015//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	9.5	8.9	9.0	8.5	8.7
Numerator	325	290	295	280	289
Denominator	3422460	3261716	3274059	3303959	3324732
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The death rates from unintentional injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check-up events are a regular Safe Kids activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties, 104 fewer deaths than expected had the fatality rates been the same. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than in non-Safe Kids counties, 110 fewer deaths than expected had the rates been the same. //2014//

/2015/ In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 40 percent lower than the rate in non-Safe Kids counties, 144 fewer deaths than expected had the fatality rates been the same. //2015//

Safe Kids Florida, Injury Prevention Program staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence.

/2014/ The counties Safe Kids currently covers are Baker, Bay, Broward, Clay, Collier, Dade,

Duval, Flagler, Hillsborough, Lake, Lee, Leon, Sumter, Manatee, Marion, Nassau, Okaloosa, Orange, Palm Beach, Pasco, Pinellas, Polk, Putnam, St. Johns, Santa Rosa. Sarasota, Sumter, and Volusia. //2014//

/2015/ In addition to counties listed above, Safe Kids now operates in Alachua,, Bradford, Columbia,, Dixie, Gilchrist, Levy, Sarasota, Seminole, and Union. (November 2012) //2015//

The death rate per 100,000 due to unintentional injuries among children aged 14 and younger remained relatively stable from 2005 to 2007. In 2008, the death rate decreased 20 percent from the previous year, but increased slightly in 2009. Overall, the death rate decreased 16 percent from 2005 to 2009. This decrease is due in part to a decrease in motor vehicle deaths.

/2014/ Data for 2011 shows a death rate due to unintentional injuries among children aged 14 years and younger of 9.01 per 100,000. This rate is consistent with the rates in the previous few years. //2014//

/2015/ Data for 2012 shows a death rate due to unintentional injuries among children aged 14 years and younger of 8.47 per 100,000. This rate is the lowest it has been in the previous few years of 9.0 in 2011, 8.9 in 2010, and 9.5 in 2009. //2015//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	2.1	2.0	2.1	1.8	1.9
Numerator	72	64	69	60	62
Denominator	3422460	3261716	3274059	3303959	3324732
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The rates of all non-fatal injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check up events are a regular Safe Kids' activity. In 2009, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 116 fewer deaths than expected had the fatality rates been the same.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties, which corresponds to 104 fewer deaths

than expected had the fatality rates been the same. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected had the fatality rates been the same. //2014//

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes decreased almost every year between 2005 and 2009. Overall, the death rate decreased 50 percent from 2005 to 2009.

/2014/ Data for 2011 show the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 2.1 in 2011. This rate is consistent with the rates in the previous few years of 2.0 in 2010, 2.1 in 2009, and 1.9 in 2008. //2014//

/2015/ Data for 2012 show the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 1.8 in 2012. This rate is consistent with the rates in the previous few years of 2.1 in 2011, 2.0 in 2010, and 2.1 in 2009. //2015//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	20.9	18.1	16.9	18.0	16.4
Numerator	505	441	413	443	405
Denominator	2413540	2437270	2442802	2459267	2467878
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The 2005-2009 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing the Primary Seat Belt law, effective June 30, 2009, we anticipate increased seat belt usage, which should further reduce motor vehicle crash injuries and deaths.

The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years decreased every year from 2005 to 2009. Overall, the death rate decreased 39 percent from 2005 to 2009.

/2014/ The death rate per 100,000 for unintentional injuries among children aged 15 through 24 years has continued to decrease every year. The rate was 16.9 in 2011, a 7 percent decrease

from the 2010 rate of 18.1, which is a 13 percent decrease from the 2009 rate of 20.9. //2014//

/2015/ The death rate per 100,000 for unintentional injuries among children aged 15 through 24 years was 18.0 in 2012, a 6 percent increase from the 2011 rate of 16.9, which is a 7 percent decrease from the 2010 rate of 18.1. //2015//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	183.3	187.8	181.5	182.7	131.8
Numerator	6274	6127	5944	6057	4383
Denominator	3422460	3261716	3274059	3314695	3324732
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

Narrative:
The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 36 of the 67 counties and covers 81 percent of the children ages 19 and under. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check-up events are a regular Safe Kids' activity.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 104 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28 percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected had the fatality rates been the same. //2014//

/2015/ In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 40 percent lower than the rate in non-Safe Kids counties which corresponds to 144 fewer deaths than expected had the fatality rates been the same. //2015//

Safe Kids Florida, Injury Prevention Program staff, is working to establish additional Safe Kids

Chapters in areas without a Safe Kids presence. Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger decreased each year from 2005 to 2007. However, the hospitalization rate increased 3 percent in 2008 and 2.7 percent in 2009. The increase from 2007 to 2009 was almost 5 percent.

/2014/ The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger was 181.6 per 100,000 in 2011, a 3.4 percent decrease from the 2010 rate of 187.9 per 100,000. //2014//

/2015/ The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger was 182.7 per 100,000 in 2012, a 0.6 percent increase from the 2011 rate of 181.6 per 100,000. //2015//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	22.7	21.3	19.8	17.2	13.3
Numerator	777	695	649	571	443
Denominator	3422460	3261716	3274059	3314695	3324732
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

Narrative:
The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 19 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Injury Prevention Program is the lead agency for Safe Kids Florida, the statewide organization. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check-up events are a regular Safe Kids' activity.

/2013/ In 2010, the childhood unintentional injury fatality rate in Safe Kids counties was 30 percent lower than the rate in non-Safe Kids counties which corresponds to 104 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. //2013//

/2014/ In 2011, the childhood unintentional injury fatality rate in Safe Kids counties was 28

percent lower than the rate in non-Safe Kids counties which corresponds to 110 fewer deaths than expected had the fatality rates been the same. //2014//

/2015/ In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 40 percent lower than the rate in non-Safe Kids counties which corresponds to 144 fewer deaths than expected had the fatality rates been the same. //2015//

Safe Kids Florida, Injury Prevention Program staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. Two chapters were recently established, one in Bay and on in Lake county. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger decreased every year from 2005 to 2009. Overall, the hospitalization rate decreased 33 percent from 2005 to 2009.

/2014/ The hospitalization rate per 100,000 of non-fatal-injuries due to motor vehicle crashes among children aged 14 years and younger decreased every year from 2008 to 2011, from 23.1 in 2008 to 19.8 in 2011, a decrease of 14.3 percent. //2014//

/2015/ In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 40 percent lower than the rate in non-Safe Kids counties which corresponds to 144 fewer deaths than expected had the fatality rates been the same. //2015//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	128.0	115.9	112.6	115.9	80.9
Numerator	3090	2825	2751	2865	1997
Denominator	2413540	2437270	2442802	2471366	2467878
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator is just first six months of data for 2012.

Narrative:
The 2003-2007 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, etc., decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing a primary seat belt law, effective June 30, 2009, we anticipate increased belt usage, which should have a corresponding reduction in

motor vehicle crash injuries and deaths.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years increased from 2005 to 2006. However, the hospitalization rate decreased each year from 2006 to 2009 for a 24 percent decrease overall.

/2014/ Data for 2011 show a rate of 112.6 per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. This represents a decrease of 3 percent from the rate of 115.9 per 100,000 in 2010 and a 12 percent decrease from the rate of 128 per 100,000 in 2009. //2014//

/2015/ In 2012, the childhood unintentional injury fatality rate in Safe Kids counties was 40 percent lower than the rate in non-Safe Kids counties which corresponds to 144 fewer deaths than expected had the fatality rates been the same. //2015//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	33.8	33.5	32.3	30.9	29.0
Numerator	19858	19554	18970	18160	16925
Denominator	588376	583708	588009	586777	583912
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Close examination of the disease distribution reveals that 80 percent of all reported cases of chlamydia are reported in populations 26 and under. Chlamydia trachomatis is the most prevalent sexually transmitted bacterial infection reported among persons age 15 to 24. The highest rate among females was in the 20 to 24 age group (34.3 per 1,000); the rate for females in the 15 to 19 age group was slightly lower at 33.3 per 1,000 population. The high rates of chlamydia seen in females may be due to existing policy which places stronger emphasis on screening and treatment of chlamydia in women than in men.

/2014/ Provisional data for 2012 indicate a rate of 30.9 per 1,000 women aged 15 through 19 years with a reported case of chlamydia. The highest rate among females was in the 20 to 24 age group, with provisional data for 2012 indicating a rate of 36.6 per 1,000 with a reported case of chlamydia, which is greater than the rate of 34.9 per 1,000 in that age group for 2001. //2014//

/2015/ Final data for 2012 shows a rate of 30.9 per 1,000 women 15 through 19 with a reported case of chlamydia, and a provisional rate of 29 per 1,000 for 2013. //2015//

Chlamydia trends and rates continue to rise in persons age 15 to19 in the state. Some of this rise may be explained by the increase in testing, improved access to care afforded to clients in clinics and local health departments, increase in electronic lab reporting, and shifting of testing technology to an more sensitive and specific test in the past two years. Additionally, increased

disease awareness, HEDIS performance measures, and Healthy People 2020 benchmarks have prompted communities to increase screening in a population of sexually active females that has been previously underserved as well as uninsured.

Adolescent women may have a physiologically increased susceptibility to chlamydia trachomatis infection. The higher prevalence of STDs among adolescents reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. Early chlamydia detection and prevalence monitoring remains a priority nationwide. The American Congress of Obstetricians and Gynecologists (ACOG) and Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for all sexually active women under age 26, as well as older women with risk factors such as new or multiple sex partners. Infertility Prevention Project (IPP), Healthy People 2020 and the National Committee for Quality Assurance HEDIS (Healthcare Effectiveness Data and Information Set) indicators monitor progress towards these goals and ultimately aim to reduce disparities.These strategies along with improved access to effective STD prevention and treatment services in local communities are imperative to the reduction of chlamydia transmission within Florida's population.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	10.9	11.3	11.5	12.2	13.1
Numerator	31650	32588	34080	36360	39077
Denominator	2916948	2888081	2956586	2974662	2990926
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Reported chlamydia infections increase each year. Approximately 76,191 chlamydia cases were reported in 2011. Reported cases among female cases aged 20 through 44 years of age accounted for 45 percent (34,006) of all reported chlamydia cases in Florida. The number of cases in this cohort increased 4.4 percent from 2010 to 2011.

/2014/ A total of 77,854 chlamydia cases were reported in 2012. Reported cases among female cases aged 20 through 44 years of age accounted for 47 percent (36,360) of all reported chlamydia cases in Florida. The number of cases in this cohort increased 6.6 percent from 2011 to 2012. //2014//

National trends indicate chlamydia infections are most prevalent in women under the age of 25. When compared by quintiles the case rate of 34.9 per 1,000 among 20-24 year olds females is higher than any other age specific rate. The rate for females in the 15-19 age-groups was slightly lower at 32.3 per 1,000. Historically, chlamydia morbidity is low in females over the age of 30. Rates of infection in females under 30 were more than five times the rates of older women. The

vast differences in the distribution of chlamydia infections by age are caused by higher biological susceptibility to STD infections, risky sexual behaviors, and a combination of other factors that leave adolescents and young adults disproportionately affected with chlamydia compared to older populations.

/2014/ Provisional data for 2012 indicate a case rate of 39.6 per 1,000 for women 20-24, which remains higher than any other age specific rate. The rate for females in the 15-19 age-groups was lower, at 30.9 per 1,000. //2014//

The Bureau of STD supports the national screening criteria recommended by the Centers for Disease Control and Prevention. The bureau also aligns with revised Healthy People 2020 STD Objectives for chlamydia screening. The highest rates of chlamydia seen in females 20-24 in recent years may be due to existing policy, which places stronger emphasis on screening and treatment of chlamydia in women than in men.

/2015/ Final data for 2012.indicate a rate of 12.2 per 1,000 for women aged 20 through 44 with a reported case of chlamydia, and a provisional rate of 18.1 per 1,000 for 2013. //2015//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	211231	147867	52040	2475	8170	679	0	0
Children 1 through 4	880025	616038	216807	10310	34039	2831	0	0
Children 5 through 9	1112712	791057	262437	12778	43258	3182	0	0
Children 10 through 14	1140733	821375	263071	13269	39908	3110	0	0
Children 15 through 19	1200272	861672	281883	14005	39186	3526	0	0
Children 20 through 24	1282463	939462	279536	14440	44981	4044	0	0
Children 0 through 24	5827436	4177471	1355774	67277	209542	17372	0	0

Notes - 2015

Narrative:
Population estimates for 2011 show there were 5,798,317 children younger than 24. Of that number, 4,298,316 (74.1 percent) are white and 1,274,976,154 (22 percent) are black. Florida only gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on proportion of 2010 deliveries in that racial group. Of all children up through age 24, we estimate there were 13,670 American Indians or Native Alaskans (0.24 percent), 81,875 Asians (1.4 percent), and 2,235 Native Hawaiians or other Pacific Islanders (0.04 percent). A total of 127,245 (2.2 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21.

/2014/ Population estimates for 2012 show there were 5,786,061children younger than 24. Of that number, 3,808,696 (65.8 percent) are white and 1,242,781 (21.5 percent) are black. Florida only gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on proportion of 2011 deliveries in that racial group. Of all children up through age 24, we estimate there were 44,445 American Indians or Native Alaskans (0.77 percent), 266,528 Asians (4.8 percent), and 7,293 Native Hawaiians or other Pacific Islanders (0.13 percent). A total of 416,319 (7.2 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21. While the population of Florida continues to grow more diverse, the significant changes from the previous year's estimates is probably due to more accurate reporting and more people describing themselves as more than one race. //2014//

/2015/ Population estimates for 2013 show there were 5,827,4361children younger than 24. Of that number, 4,177,471 (71.7 percent) are white and 1,365,774 (23.3 percent) are black. Florida only gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on estimates from census data. Of all children up through age 24, we estimate there were 67,277 American Indians or Native Alaskans (1.2 percent), 209,542 Asians (3.6 percent), and 17,232 Native Hawaiians or other Pacific Islanders (0.3 percent). There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21. The changes from the previous year's estimates is due to getting the data from the census, which did not take into account people describing themselves as more than one race. //2015//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	152949	58282	0
Children 1 through 4	610310	269715	0
Children 5 through 9	783285	329427	0
Children 10 through 14	814695	326038	0
Children 15 through 19	860716	339556	0
Children 20 through 24	931948	350515	0
Children 0 through 24	4153903	1673533	0

Notes - 2015

Narrative:
Florida does not gather data on the number of Hispanics. In order to complete HSI #06B the Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2011 population of 0-24 year olds by race-ethnicity. According to those projections, of the 5,798,317 children 24 or younger, 1,544,437 (26.6 percent) are identified as Hispanic or Latino.

/2014/ According to 2012 population projections, of the 5,786,061 children 24 or younger, 1,627,291 (28 percent) are identified as Hispanic or Latino. //2014//

/2015/ According to 2013 population projections, of the 5,827,436 children 24 or younger,

1,673,533 (28.7 percent) are identified as Hispanic or Latino. //2015//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	164	75	84	0	0	0	4	1
Women 15 through 17	3698	2267	1263	6	13	3	110	36
Women 18 through 19	10258	6483	3328	22	51	7	264	103
Women 20 through 34	167324	119609	37920	219	4520	220	2440	2396
Women 35 or older	33744	24843	6142	35	1554	46	449	675
Women of all ages	215188	153277	48737	282	6138	276	3267	3211

Notes - 2015

Narrative:
Provisional data for 2011 indicate there were 212,699 total live births in Florida. This represents a decrease from the previous year as 213,425 total births were reported in 2010. Of the 2011 provisional total, 151,590 were white (71.3 percent), 48,747 were black (22.9 percent), 324 were American Indian or Native Alaskan (0.15 percent), 6,387 were American Indian or Native Alaskan (3 percent), and 140 were Native Hawaiian or Other Pacific Islander (0.07 percent). More than one race was reported for 2,753 births (1.3 percent) and 2,758 births were other or unknown (1.3 percent).

Of the total births, women younger than 15 had 190 babies (0.09 percent of the total), women 15 through 17 had 4,691 babies (2.2 percent), women 18 through 19 had 12,339 babies (5.8 percent), women 20 through 34 had 162,748 babies (76.5 percent), and women 35 or older had 32,731 babies (15.4 percent).

/2014/ Provisional data for 2012 indicate there were 212,380 total live births in Florida. Of the 2012 provisional total, 150,427 were white (70.8 percent), 48,882 were black (23 percent), 302 were American Indian or Native Alaskan (0.14 percent), 6,267 were American Indian or Native Alaskan (3 percent), and 245 were Native Hawaiian or Other Pacific Islander (0.12 percent). More than one race was reported for 3,150 births (1.5 percent) and 3,107 births were other or unknown (1.5 percent). Of the total births, women younger than 15 had 186 babies (0.09 percent of the total), women 15 through 17 had 4,193 babies (2 percent), women 18 through 19 had 11,651 babies (5.5 percent), women 20 through 34 had 163,616 babies (77 percent), and women 35 or older had 32,734 babies (15.4 percent). //2014//

/2015/ Data for 2013 indicate there were 215,188 total live births in Florida. Of the 2013 total, 153,277 were white (71.2 percent), 48,737 were black (22.6 percent), 282 were American Indian or Native Alaskan (0.13 percent), 6,138 were American Indian or Native Alaskan (2.85 percent), and 276 were Native Hawaiian or Other Pacific Islander (0.13

percent). More than one race was reported for 3,267 births (1.5 percent) and 3,211 births were other or unknown (1.5 percent). Of the total births, women younger than 15 had 164 babies (0.08 percent of the total), women 15 through 17 had 3,698 babies (1.7 percent), women 18 through 19 had 10,258 babies (4.8 percent), women 20 through 34 had 167,324 babies (77.8 percent), and women 35 or older had 37,744 babies (17.3 percent). //2015//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	118	45	1
Women 15 through 17	2529	1146	23
Women 18 through 19	7374	2841	43
Women 20 through 34	121462	44761	1101
Women 35 or older	23209	10290	245
Women of all ages	154692	59083	1413

Notes - 2015

Narrative:
Of the 212,699 births in 2011 (provisional), 152,945 (71.9 percent) were not Hispanic or Latino, 58,584 (27.5 percent) were Hispanic or Latino, and 1,170 (0.6 percent) were ethnicity not reported.

/2014/ Of the 212,380 births in 2012 (provisional), 153,098 (72 percent) were not Hispanic or Latino, 57,751 (27.2 percent) were Hispanic or Latino, and 1,531 (0.7 percent) were ethnicity not reported. //2014//

/2015/ Of the 215,188 births in 2013, a total of 154,692 (71.9 percent) were not Hispanic or Latino, 59.083 (27.5 percent) were Hispanic or Latino, and 1,413 (0.7 percent) were ethnicity not reported. //2015//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1318	707	517	2	12	1	59	20
Children 1 through 4	253	153	78	1	7	0	13	1
Children 5 through 9	131	72	48	1	2	2	4	2

Children 10 through 14	170	120	41	0	5	1	2	1
Children 15 through 19	502	320	146	1	3	1	21	10
Children 20 through 24	1087	711	328	1	11	0	22	14
Children 0 through 24	3461	2083	1158	6	40	5	121	48

Notes - 2015

Narrative:
Of the 3,577 in 2011 total deaths to children 24 and younger, 2,138 (59.8 percent) were white, 1,241 (34.7 percent) were black, 5 were American Indian or Native Alaskan (0.14 percent), 41 were Asian (1.1 percent), 101 were more than one race reported (2.8 percent), and 51 (1.4 percent) were other or unknown. There were 1,344 deaths from birth to age 1, white infants accounted for 681 deaths (50.7 percent) and black infants accounted for 573 deaths (42.6 percent) in that age category, yet black infants account for just 22.9 percent of infants 0-1. Black children account for 22 percent of the population in all other ages groups on this form, yet they account for 31.6 percent of the deaths in children 1 through 4; 33.3 percent of the deaths in children 5 through 9; 28.2 percent of the deaths in children 10 through 14: 26.5 percent of the deaths in children 15 through 19: and 31.2 percent of the deaths in children 20 through 24. Overall, in children from birth through 24, black children account for 22 percent of the population, and 34.7 percent of the deaths. In contrast, white children account for 74 percent of the population from birth through 24, but only 59.8 percent of the deaths.

/2014/ In 2012, of the 3,459 total deaths to children 24 and younger, 2,138 (61.9 percent) were white, 1,153 (33.3 percent) were black, 7 were American Indian or Native Alaskan (0.2 percent), 29 were Asian (0.8 percent), 1 was Native Hawaiian or other Pacific Islander (0.03 percent), 84 were more than one race reported (2.4 percent), and 47 (1.4 percent) were other or unknown. /2014//

/2015/ In 2013, of the 3,481 total deaths to children 24 and younger, 2,083 (59.8 percent) were white, 1,158 (33.3 percent) were black, 6 were American Indian or Native Alaskan (0.2 percent), 40 were Asian (1.15 percent), 5 were Native Hawaiian or other Pacific Islander (0.15 percent), 121 were more than one race reported (3.5 percent), and 48 (1.4 percent) were other or unknown. /2015/

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1034	261	23
Children 1 through 4	187	66	0
Children 5 through 9	99	32	0
Children 10 through 14	126	43	1
Children 15 through 19	396	103	3
Children 20 through	886	191	10

24			
Children 0 through 24	2728	696	37

Notes - 2015

Narrative:
Of the 3,637 total deaths to children 24 and younger, 2,877 (79 percent) were not Hispanic or Latino. Of the total deaths, 754 (20.8 percent) were Hispanic or Latino, even though children of those ethnicities account for 26.3 percent of the children 0 through 24. Hispanic or Latino infants account for 28.9 percent of infants from birth to 1, but only 22.9 percent of the infant deaths.

/2014/ Of the 3,459 total deaths to children 24 and younger, 2,677 (77.4 percent) were not Hispanic or Latino. Of the total deaths, 755 (21.8 percent) were Hispanic or Latino, even though children of those ethnicities account for 28.1 percent of the children 0 through 24. Hispanic or Latino infants account for 26.5 percent of infants from birth to 1, but only 22.8 percent of the infant deaths. //2014//

/2015/ In 2013, of the 3,481 total deaths to children 24 and younger, 2,728 (78.8 percent) were not Hispanic or Latino. Of the total deaths, 696 (20.1 percent) were Hispanic or Latino. //2015//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	4517889	3198833	1003525	30340	163833	6068	115290	0	2013
Percent in household headed by single parent	40.0	30.0	65.0	15.0	15.0	15.0	48.0	0.0	2013
Percent in TANF (Grant) families	1.2	0.9	2.4	0.4	0.0	3.0	0.0	0.0	2013
Number enrolled in Medicaid	2349132	1381904	831764	4897	26199	972	39	103357	2013
Number enrolled in SCHIP	368400	124861	42234	141	5380	893	9644	185247	2013
Number living in foster home care	15964	9816	5055	46	28	3	943	73	2013
Number enrolled in food stamp program	1834010	787728	601299	3327	8596	5197	24472	403391	2013
Number enrolled in WIC	427670	261871	132195	2960	5179	799	24666	0	2013

Rate (per 100,000) of juvenile crime arrests	1848.0	1360.0	3712.0	218.0	168.0	1335.0	0.0	0.0	2013
Percentage of high school drop-outs (grade 9 through 12)	2.0	1.5	3.4	2.4	0.6	1.7	1.7	2.0	2013

Notes - 2015

Narrative:
/2015/ Of children 19 and younger in Florida, 40 percent live in a household headed by a single parent, 35 percent of white children and 65 percent of black children. About 1.2 percent of all children live in families that receive Temporary Assistance for Needy Families (TANF) grants, 0.9 percent of white children and 2.4 percent of black children. There are 2,349,132 children 19 and younger on Medicaid, 1,381,904 white children and 831,764 black children. A total of 368,400 children are enrolled in SCHIP, 124,861 white children and 42,234 black children. Of the 15,964 children 19 and younger in foster care, 9,816 are white and 5,055 are black. A total of 1,834,010 children are enrolled in the food stamp program, 787,728 white children and 601,299 black children. There are 427,670 children enrolled in WIC, 261,871 white children and 132,185 black children. The rate for juvenile crime arrest in Florida is 1,848 per 100,000, with a rate of 1,360 per 100,000 for whites and 3.172 per 100,000 for blacks. In Florida, 2 percent of children are high school dropouts, 1.5 percent of white children and 3.4 percent of black children. Numbers or estimates for other races can be found in Form 21, #09A. //2015//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	3208469	1309420	0	2013
Percent in household headed by single parent	30.0	40.0	0.0	2013
Percent in TANF (Grant) families	1.4	0.7	0.0	2013
Number enrolled in Medicaid	1637325	711768	39	2013
Number enrolled in SCHIP	368400	115800	252600	2013
Number living in foster home care	11433	2475	2056	2013
Number enrolled in food stamp program	1205715	628295	0	2013
Number enrolled in WIC	255786	171833	51	2013
Rate (per 100,000) of juvenile crime arrests	2230.0	912.0	0.0	2013
Percentage of high school drop-outs (grade 9 through 12)	2.1	1.9	0.0	2013

Notes - 2015

Narrative:

/2015/ Of children 19 and younger identified as Hispanic or Latino, 40 percent live in a household headed by a single parent. About 0.7 percent of Hispanic or Latino children live in TANF families, compared to 1.5 percent of children who are not Hispanic or Latino. Of the 2,349,132 children 19 and younger on Medicaid, 711,768 are Hispanic or Latino. Of the 368,400 children enrolled in SCHIP, 116,800 are identified as Hispanic or Latino. Of the 15,964 children 19 and younger in foster care, 2,475 are Hispanic or Latino. Hispanic or Latino children account for 628,295 of the 1,834,010 children in the food stamp program. Of the 427,670 children in WIC, Hispanic or Latino children account for 171,833 of the total. The rate for juvenile crime arrest for Hispanic or Latino children is 912 per 100,000. About 1.9 percent of Hispanic or Latino children are high school dropouts. //2015//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	4228744
Living in rural areas	289145
Living in frontier areas	0
Total - all children 0 through 19	4517889

Notes - 2015

Narrative:
/2012/ In Florida, 4,324,937 children 19 and younger live in urban areas and 300,665 live in rural areas. //2012//

/2014/ In Florida, 4,194,708 children 19 and younger live in urban areas and 286,818 live in rural areas. //2014//

/2015/ In Florida, 4,228,744 children 19 and younger live in urban areas and 289,145 live in rural areas. //2015//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	19318859
Percent Below: 50% of poverty	7.4
100% of poverty	21.9
200% of poverty	37.5

Notes - 2015

Narrative:
/2012/ Of the 18,819,000 people living in Florida, we estimate that 5.7 percent live below 50 percent of the federal poverty level. Approximately 15.6 percent live below 100 percent of the federal poverty level and 35.3 percent live below 200 percent of the federal poverty level. //2012//

/2015/ Of the 19,318,859 people living in Florida, we estimate that 7.4 percent live below 50 percent of the federal poverty level. Approximately 21.9 percent live below 100 percent of the federal poverty level and 37.6 percent live below 200 percent of the federal poverty level. //2015//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	4517889
Percent Below: 50% of poverty	10.1
100% of poverty	26.9
200% of poverty	45.4

Notes - 2015

Narrative:
/2012/ Of the 4,625,602 children 19 and younger living in Florida, we estimate that 7.9 percent live below 50 percent of the federal poverty level. Approximately 19.6 percent live below 100 percent of the federal poverty level and 43.1 percent live below 200 percent of the federal poverty level. /2012/

/2015/ Of the 4,517,889 children 19 and younger living in Florida, we estimate that 10.1 percent live below 50 percent of the federal poverty level. Approximately 26.9 percent live below 100 percent of the federal poverty level and 45.4 percent live below 200 percent of the federal poverty level.//2015//

F. Other Program Activities

Childhood Lead Poisoning Prevention Initiative: A Department of Health program through which the environmental health program works with county health departments to enhance their data collection and case management capabilities for following and treating children with elevated blood lead levels.

Comprehensive Child Health Services: Child health services are provided to children age birth to 21 in most of the 67 county health departments in Florida. Counties may also contract services to private providers or other agencies. Comprehensive child health services are designed to integrate preventive health services and health promotion while minimizing cultural, geographic and financial barriers to care.

Every Woman Florida: A preconception health initiative that increases awareness on the importance of good preconception health. One of the goals of this initiative is to improve the integration of preconception health within all clinical settings. Another goal is to ensure the health of women of childbearing age. The Every Woman Florida website serves as a portal for preconception information for both providers and patients. The Every Woman Florida Preconception Health Council is responsible for guiding the integration of preconception care in clinical and public health practice throughout Florida.

Family Health Line: A toll-free hotline that promotes the importance of early and continuous prenatal and infant care. The hotline provides basic information on pregnancy and how to access prenatal care, infant care, family planning, WIC, drug abuse treatment, and other pregnancy-related services. The hotline also arranges referrals to private, public, and volunteer health promotion groups.

Fetal and Infant Mortality Review: An information-gathering process designed to identify deficiencies in the maternal and infant health care system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.

Florida Folic Acid Coalition: The Florida Folic Acid Coalition (FFAC) was created in 1999 to ensure that women in Florida and their health care providers are aware of the benefits of folic acid in decreasing the risk of birth defects of the brain and spine usually referred to as neural tube defects. Comprised of public and private partners throughout the state, the group supports a wide range of educational activities that have contributed to documented increases in what health care providers and women of childbearing age know about folic acid. The coalition seeks to establish folic acid education as a routine and standard part of the delivery of preventive health care services, as well as increase awareness and education of the nutritional and health benefits of folic acid across the lifespan.

Pregnancy Associated Mortality Review: A population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in the service delivery system for women.

Pregnancy Risk Assessment Monitoring System: The PRAMS project conducts population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, in 35 states and the District of Columbia.

Reach Out and Read: An early literacy program that involves pediatricians and nurses supporting children's language and literacy development through various interventions.

Responsible Fatherhood Project: This project encourages fathers of children (age birth to 5) to become better fathers by making available resources, support, information and education. The project also seeks to increase awareness in the local community of the importance of fathers being actively involved with the care of their children.

Sexual Violence Prevention Program: The primary goals of the Sexual Violence Prevention Program (SVPP) are to provide statewide, integrated, primary rape prevention education; services to rape victims; county health department screening and assistance for domestic violence victims; and information on human trafficking. Additionally, the SVPP develops program and policy guidelines, responds to legislative issues, and manages a public awareness campaign called "Rape. Talk About It. Prevent It" comprised of radio and television public service announcements, and print media aimed to educate 10-24 year-olds about rape prevention.

Staff Development, Education and Training: MCH staff develops training materials targeted towards MCH providers. They provide ongoing training and technical assistance to increase skills needed to screen, assess, identify needs, coordinate and provide services.

Statewide Birth Defects Surveillance System: A system designed to reduce the impact of birth defects, investigate possible causative agents, disseminate information, and plan and evaluate the effects of interventions. Of added importance, the file linkage efforts used to develop the birth defects surveillance system also links other datasets to vital records that are used for other maternal and child health purposes. These linked file efforts are of importance because they address identified block grant priorities and are therefore supported by MCH Block Grant funding.

Sudden Unexpected Infant Death Syndrome: The Department of Health oversees the professional support activities offered to people affected by SIDS. Activities focus on increasing the awareness of SIDS and providing the latest prevention information to health providers and trainers of secondary caregivers, such as childcare providers.

Voluntary Pre-Kindergarten: A program designed to prepare 4-year-olds for kindergarten and build the foundation for their educational success. The program allows a parent to enroll his or her eligible child (four years old by September 1 and residing in Florida) in a free VPK program.

G. Technical Assistance

We are requesting technical assistance to identify sources of data for certain performance measures and some of the forms where it is unclear about where to get the data.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	18904025	18904025	18920363		18996748	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	169390341	169390341	169402594		169459883	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	188294366	188294366	188322957		188456631	
8. Other Federal Funds *(Line10, Form 2)*	362324908	362324908	415342314		378242185	
9. Total *(Line11, Form 2)*	550619274	550619274	603665271		566698816	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	35775930	35775930	35781362		35806760	
b. Infants < 1 year old	5648831	5648831	5649689		5653699	

c. Children 1 to 22 years old	65938028	65938028	65913035		65959821	
d. Children with Special Healthcare Needs	62137141	62137141	62146575		62190688	
e. Others	0	0	0		0	
f. Administration	18794436	18794436	18832296		18845663	
g. SUBTOTAL	188294366	188294366	188322957		188456631	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	65357		66392		45305	
c. CISS	0		0		0	
d. Abstinence Education	2787643		2829101		2740351	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	199194063		235279327		205669553	
h. AIDS	0		0		0	
i. CDC	15113250		14244365		12844753	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
see notes					156942223	
Other Funds			53893782			
USDA CACFP Grant			109029347			
others (see notes)	50072987					
USDA CACFP grant	95091608					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	33892986	33892986	35781362		35806760	
II. Enabling Services	79083634	79083634	79095642		79151785	
III. Population-Based Services	26361211	26361211	24481984		24499362	
IV. Infrastructure Building Services	48956535	48956535	48963969		48998724	
V. Federal-State Title V	188294366	188294366	188322957		188456631	

Block Grant Partnership Total						

A. Expenditures

There were no significant variations in expenditures in forms 3, 4, and 5 from previous years. Expenditure data for Florida is included on forms 3, 4, and 5.

B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the $18,996,748 budgeted as the expected federal allotment for FY2015, a total of $6,064,675 is budgeted for preventive and primary care for children (31.9 percent), $8,539,800 for children with special health care needs (45 percent), which meet the 30 percent requirements. In addition, $1,818,087 (9.6 percent) is budgeted towards Title V administrative costs. Total state match for FY2015 is $169,459,883, which exceeds the state's FY 1989 maintenance of effort amount of $155,212,322. Sources of other federal funds include the SSDI grant, Abstinence Education, WIC, CDC grant awards, the USDA CACFP grant, Florida's Medipass Waiver, Family Planning, School Health, and Preventive Health and Health Services Block Grant. A complete list of other federal funds with funding amounts is included on Form 2 and the notes for Form 2. Budget numbers for Florida are included on forms 2, 3, 4, and 5.

It should be noted that in the event of an emergency, unless granted a temporary exemption from emergency duty, all Department of Health staff may be required to work before, during and/or beyond their normal hours or days in a special needs shelter, Red Cross shelter, Emergency Operations Command Center (EOCC), or to perform other emergency duties, including, but not limited to, responses to or threats involving any disaster or threat of disaster, man-made or natural.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.